



Inglis, Sheila M.C. (1993) *Inabstinent women: the drunken threat*. PhD thesis.

<http://theses.gla.ac.uk/3196/>

Copyright and moral rights for this thesis are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the Author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the Author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

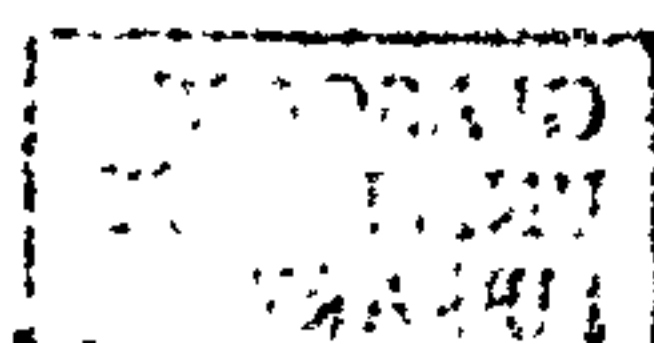
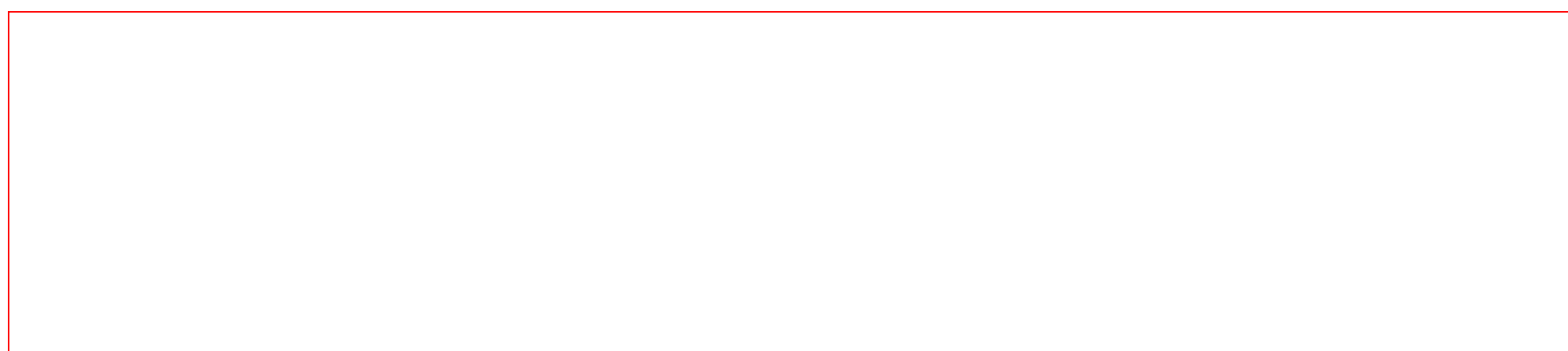
**INABSTINENT WOMEN:
THE DRUNKEN THREAT**

SHEILA M.C. INGLIS

PhD

**UNIVERSITY OF GLASGOW
DEPARTMENT OF SOCIOLOGY**

October 1993



ABSTRACT

My thesis is that femininity is constructed as abstinent, in particular, as abstinent from public, productive labour and from the active expression of desire/pleasure. Further, that the enforcement of women's abstinence through psychiatric, psychological and sociological discourses on femininity ensures the means of patriarchal expression. Women's inabstinence, therefore, poses a threat to patriarchal expression, and insofar as patriarchy is realised through patriarchal expression, to the stability of patriarchal society. Women's drunken inabstinence, however, provides only a temporary, individualised and often self-destructive omen of the threat.

My fieldwork focuses on the processes and experiences through which women come to be administered as 'alcoholic'/'problem drinkers'. My meetings and discussions with alcohol and drug agency workers and with women administratively defined as 'alcoholic'/'problem drinkers' explicated the processes of the social control of all women in terms of the containment and privatisation of their active collective pursuit of pleasure. Drunken women's struggle against the strictures of femininity expresses the beginnings of a threat to patriarchy; however, insofar as the characteristics of femininity itself are 'drunken' in their demands for dependency, patriarchal accessibility and a dislocation from public/productive activity, drunkenness as a critique of patriarchy is self-defeating. The challenge to patriarchy comes only in women's sober, collective refusal to abstain from passion.

CONTENTS

Introduction:.....	1
Chapter 1: Abstinent Division.....	31
Chapter 2: The Rule of the Father.....	79
Chapter 3. The Empirical Continuum.....	130
Chapter 4: Equal Opportunities for Women and Alcohol.....	183
Chapter 5: Femininity, Drunkenness and Dependence.....	227
Chapter 6: Defining a Standpoint.....	291
Chapter 7: Women Drinking.....	346
Chapter 8: Treating Women.....	389
Conclusion:.....	419
Notes:.....	427
Appendix 1: Postal Questionnaire.....	439
Appendix 2: Directory of Agencies Surveyed.....	443
Appendix 3: Survey of Services for Drunken Women in Glasgow.....	450
Appendix 4: Discussion Schedules.....	454
Appendix 5: Location of Discussions.....	459
Appendix 7: Tabulated Findings.....	464
References:.....	472

INTRODUCTION

My aim is to provide some insight into the processes of the social control of women as it occurs through the construction of femininity as abstinent - in particular, femininity as abstinent from public, productive labour and also from the active/public expression of desire/ pleasure. And my general thesis is that although women's inabstinence in both of these spheres provides a threat to patriarchal stability, women's *drunken* inabstinence provides only an temporary, individualised and sometimes self-destructive omen of the threat. My contention is that the characteristics of femininity itself are 'drunken' insofar as they demand dependency, patriarchal accessibility and a dislocation from public/productive activity. Thus when women seek relaxation, pleasure or escape through drinking, they usually find themselves caricatur ing the sexualised dependency that defines femininity; and almost always find themselves censured for such inabstinence in terms of that caricature. An examination of the processes of the control of drunken women explicate the processes of the

social control of all women in terms of the containment and privatisation of their active collective pursuit of pleasure.

My research comprised two areas: an 'alcoholology' literary review and analysis, and fieldwork with defined drunken women and workers in drug/alcohol agencies. The first five chapters of my thesis deal with my literary review and analysis; the final three discuss my field work.

Chapter one outlines the historical processes of the construction of abstinent femininity. I tell the story of the identification of drunkenness with general social dis-order and the development of social intervention into drunkenness. The rational Enlightenment of the seventeenth century reformed pre-modern super-Natural conceptions of the world ruled by invisible and unpredictable forces (such as Good and Evil), to establish rationality as the motive force of the cosmology. Rationality became the defining characteristic of humanity, and was defined in the Utilitarian Social Contract, wherein all individuals were equal insofar as they engaged in productive social

activity. Drunkenness as the antithesis of rational productive activity therefore became increasingly subject to social control from the seventeenth to the twentieth century. The social/political form of drunkenness as a refusal to engage in rational employment was domesticated as alcohol was commodified, available only in market terms. Alcohol was thus brought within the rational cosmology, as the expression of public market transactions - any other social consumption of alcohol remained beyond the limits of rationality: sub-human. Drunkenness became illegal insofar as it was beyond the bounds of the rational transactions of market - and drunks were banned from pubs as 'bad for business'. Utilitarian optimism foresaw the atrophification of drunkenness as the rational cosmology gained in stability; however, as irrational activity evidenced a remarkable tenacity, reformists, such as J.S. Mill conceived society not as a unified rational system, but rather as system comprising two different but complementary parts. Society was now conceived as the relationship between the 'public' realm of production and the 'private' realm of distribution and consumption. Production

as 'rational' human activity was distinguished from consumption as the means of leisured refreshment. The two parts were articulated through abstinence: leisured consumption justifiable only through capital abstinence (namely the accumulation of Utilitarian surplus value) - enforced through the development of taxation on a social level and the marital abstinence of women from waged labour on an individual level. Taxation provided the means for rational Utilitarian reform in the irrational sphere of the distribution and consumption of social goods, for example in the form of policing; and the marital abstinence of women ensured that men retained the opportunity for rational productive expression and thus also of leisured consumption (of women?). The development of the state and of state intervention in the sphere of consumption facilitated the patriarchal/
/paternalistic control of women refusing to be abstinent. The feminine rehabilitation of women provided through health and welfare intervention was backed up by the threat of physical/sexual violence. Hygiene became the effective means of the control of women and by the early twentieth

century inabstinent women were seen as both the cause and the consequence of social ills leading to national and racial decline. The role of the state was now to control the distribution and thus consumption of alcohol, rather than the distribution and consumption of women through paternalistic welfarism. Health education became the means of social welfare, with only the most incorrigible women remaining inabstinent.

Chapter two describes the positive identification of these incorrigibly inabstinent women as intrinsically pathological: from Darwin's species perspective, through Lombroso's identification of atavistic individuals, to Geddes and Thompson's analysis of the pathology of the female cell, women were empirically defined as different and less than men in terms of their irrational, underdeveloped physical compositions. In order that women may participate in rational modern society, therefore, they were required to exercise their will in resisting the irrational forces of their atavistic natures. Their successful exercise of will and thus qualification to join rational society was evidenced only in their

abstinence from publicly productive active and the active pursuit of their own leisure/pleasure.

The return of irrationality as the motive force of society, however, through Freud's theory of the unconscious, did not provide women with a legitimate means of pleasure. Instead, women's necessary abstinence was internalised: a woman was no longer simply lacking in will in being inabstinent, she was positively pathological. Freud translated the Utilitarian Social Contract into the resolution of the Oedipus Complex and the consequent development of conscience. The resolution of the Oedipus Complex required the internalisation of the law of the father in order to avoid a repetition of primordial patricide. The internalisation of patriarchy through the fear of murder in retribution for sexual desire for the mother, therefore, is identified as conscience (super-ego): the means of social order and the basis of the Social Contract. Women, however, lacking the opportunity to internalise the law of the father through the Oedipus Complex, require - for the development of their conscience (super ego) - a man who can embody the law of the father

for her: a man to provide her conscience through his authority. In particular, women's conscience, and thus qualification for civilised society, requires them to defer the gratification of their sexual/life impulse (id) to men (and babies as the produce of men) thus abstaining from active (phallic) pursuit of pleasure.

Thus the nineteenth century tension between the rational belief in equality and freedom and the material reality of inequality that was resolved through the empirical institution of the distinction between the social spheres of production and distribution, and the socially functionally necessity of the deferred gratification of some (namely women) to others (namely men) in order to ensure the general social wellbeing, gained a Freudian analysis. My contention here is that the particular form of society - namely the specific relations of the articulation of production and consumption - is defined in the specific social relations of deferred gratification (who defers pleasure/life to whom), and the specific form that abstinence takes.

Within patriarchal society, therefore, women defer gratification to men, and thus women provide the means for the articulation of society. Insofar as women fail to defer gratification to men they are conceived as failing to submit to the embodiment of the law of the father and consequently deny themselves the opportunity to develop conscience. Furthermore, not only do they lack conscience, such women suffer from psychic pathology in the form of sex-role confusion: in refusing to defer gratification to men they are seen as mimicking men which further reduced their chances of achieving qualification for civilised society. Their psychic illness is therefore regarded as a sort of "ransom of emancipation": the inevitable consequences of attempting to gratify themselves by behaving like men (for example, drinking). All women, therefore, by this standpoint, are intrinsically morally deviant in their underdeveloped conscience; deviant or inabstinent women, however, who refuse to abstain from seeking gratification are doubly deviant - truly monstrous.

Chapter three describes the development of the positivist strain between reliability and validity and the empiricist rejection of psychoanalysis as the explanation and means of cure of drunkenness. The invisible and irrational forces of sexuality that drove the psychoanalytic conception of society were renounced as classical rationalism found its twentieth century expression in temperance ideology and the institution of Alcoholics Anonymous. Here the concern was the theory of social problems, such as alcoholism, empirically fitted the experience of such problems (Denzin 1987). The psychoanalytic notion of quasi-super-Natural forces causing alcoholism rather than the empirically obvious pathogen alcohol was jettisoned as alcoholics themselves defined the theory. The development of the disease concept of alcoholism as a means of redressing the psychiatric control of alcoholics was aimed at dissolving the stigma attached to alcoholics and also to establish self-help rather than expert help as the means of recovery. The Alcoholics Anonymous model of alcoholism, therefore, both denied the inductive premises of the clinical method, and maintained that the alcoholic had not

willfully embarked upon alcoholic drinking. Both psychoanalysis and AA held onto the biological bases of alcoholism, however whilst psychoanalysis was premised upon the notion that the pathological drinker had an unevolved superego - conscience - the AA believed that the pathological drinker had an allergy to alcohol. From this standpoint, therefore, the only 'cure' for alcoholism is abstinence (from alcohol); and in the spirit of classical rationalism, the only means of abstinence is through democratic self-help. Alcoholism, therefore, was not seen as a disease of the 'will' or of the 'psyche'; rather, it was seen simply as a disease of alcohol - an impersonal, objective substance, over which the issue of individual control was both impossible and irrelevant.

Mid-twentieth century developments in psychology, particularly cognitive psychology, provided the challenge to both psychiatry and AA, however, by pointing to serious problems in both the validity of the concepts used by both parties, and the reliability of their findings (Davies 1962, Shaw et al 1978, Edwards 1970, Pattison et al 1977).

Methodologically both parties were criticised for generalising their findings from small and very specific sample populations, such as clinical patients in the case of the psychoanalysts and AA members in the case of AA. From such samples their theories could not be reliable. Furthermore, (reliable?) empirical psychological research challenged the (AA and psychoanalytic) notion that 'alcoholics' were qualitatively distinct from 'normal' individuals (Keller 1972, Davies 1974). Psychologists suggested, rather, an individual continuum of alcoholism: this ran counter to the earlier conceptions pre-determined 'separate spheres' of normal and pathological drinking. And psychology further challenged the idea of 'separate spheres' by developing the concept of a behavioural continuum of drinking wherein individual moved into and out of problem drinking over the course of their lifetime (Edwards 1977, Armor et al 1978). This latter conception allowed for the possibility of the intervention of the individual drinkers will in controlling her drinking, unlike more determinist analyses of alcoholism as pathology. Thus psychology (reliably) revalorised the rationalist utilitarian

conception of a radical equality of all individuals insofar as they exercised their will over their circumstances.

The psychological standpoint, therefore, focused attention away from both the personality and alcohol as the causes of alcoholism, and looked instead to the relationship between individual physiological and psychological experiences of alcohol, positing that alcoholic individuals learn to develop avoidance aversion drinking, in order to stave off withdrawal symptoms (hangovers) (Edwards 1977, Armor et al 1978). This is premised on the fundamental Utilitarian belief that all individuals will pursue their own interest - they will avoid aversive experiences. And furthermore, the focus is on directly observable behaviour rather than invisible, super-Natural causes.

General mental health, therefore, from the psychological standpoint required individual motivation away from aversive experiences. This was conceived as more than simply individual will, rather a more interactional approach developed to include the significance of environmental factors

(including other people) that effected motivation (Davies 1982, Orford 1977). And psychological intervention in alcoholic drinking concentrated on "reprogramming" problem drinkers lives in order that "more socially desirable" factors are dominant in "directing" their lives (Dewes 1972). Controlled drinking programmes, therefore focused on encouraging the problem/uncontrolled drinker to emotionally invest in "healthy" (socially desirable) alternatives to alcohol. And as motivation was conceived as involving emotional commitment, the nature of the doctor-patient relationship shifted from one where the doctor embodied the rule of the father in order that individual pathologically lacking in conscience may re-enter civilised society, to one of partnership: the patient was conceived as committed as the doctor to personal change (Heather 1980). An added bonus, of course was that patient contact with doctors/psychologists was minimised as patients/clients expressed their motivation and commitment in attending one appointment (Heather et al 1986) - the rest was up to them. This enables psychologists to deal with far more problem/uncontrolled individuals than

psychoanalysts. And as their potential productivity increased, so too did the market of possible patients through the notion of the alcoholic continuum, and later the concept of alcohol related harm (chapter 4).

Psychology, therefore, conceived individuals as equally healthy insofar as they learn to avoid aversive circumstances. Social-psychological research on women, however, indicated that women suffered a greater degree and a greater quantity of aversive experiences than men (Steiner & Carroll 1977, Moos 1969, Wilcoxon et al 1976, Dalton 1964). And empirically, women's physiologies were shown to be inherently unstable, preventing women's equivalent exercise of control over their circumstances with men. Women consequently learn "helplessness" (Seligman 1975). Women's physiological lack of control was found to be further consolidated by their relative lack over their social circumstances (Armor et al 1978, Pemberton 1967, Sclare 1970, Edwards et al 1972, Shaw 1980, Schuckitt 1972). This led to the possibility that the processes of socialisation were significant not only in providing gender

difference, but also in engendering women's greater propensity to psychological dependency such as alcoholic dependency.

However, in their focus upon the individual phenomena of social behaviour, psychologist failed to consider the possibility that women's psychological dependence was intrinsically related to the social requirement for the functional abstinence[^] of women. And thus treatments such as controlled drinking programmes and rational emotive therapy do not go far enough in enabling women to overcome their problems: controlled drinking assumes the possibility of asserting effective control in life/social areas beyond drinking (Mayne 1986); and rational emotive therapy assumes that women's beliefs concerning their dependence are simply "irrational", without material substance.

Chapter four discusses the influence of psychological notions of the alcoholic continuum on sociological standpoints. In particular, the Durkheimian view that rates of alcoholism in a society indicate the degree of tension in that

society and the degree to which that society is unstable. Within such analyses the relationship between the physiological and psychological experiences of alcohol broaden to describe a bio-cultural dialectic: the individual (physiological and psychological) experience of alcohol is intrinsically related to cultural beliefs regarding alcohol (Young 1971, Robinson 1977, MacAndrew & Edgerton 1969). As the manifestation and expression of essential human nature has transmogrified from the accumulation of productive capital (through capital abstinence, such as saving, taxation and marriage) to its twentieth century form of the consumption of commodities, the cultural value of alcohol has changed accordingly. In the expression of essential human nature through consumption, leisure has become increasingly important as a the key means of tension relief, and insofar as alcohol provides symbolic and material "time-out" from productive social activities (MacAndrew & Edgerton 1969, Young 1971, Willis 1975), drunkenness assumes the status of essential human nature. However, "time-out" and access to alcohol as a symbol of essential human nature is only legitimately

attainable through the "credit card of work" (Young 1971). Drunkenness and alcohol as the means to drunkenness is legitimate, therefore, only insofar as it is integrated into productive (waged) activity. Legitimate leisure, therefore, articulates the realm of production with the realm of consumption. Furthermore, insofar as women are functionally defined through consumption, women similarly become a key means of essential human (masculine) nature: a locus of masculine "time-out" and of the articulation of the ideological divorce of production from consumption. Women can only fulfil this function insofar as they abstain both from waged labour and from leisure.

The mid twentieth century concern to integrate alcohol into productive social life, therefore also implied the integration/normalisation of leisure and of women. Social Democratic consensus saw the reduction of fiscal measures encouraging/enforcing the maintenance of the symbolic status of alcohol (Room 1983) and of women as specific loci of leisure/pleasure through consumption. Cultural beliefs in alcohol as a "hazardous commodity" (Room 1983) or in women as

"unequal" were replaced by modern beliefs in the radical equality of alcohol with any other (psychotropic) commodity such as caffeine, tobacco, cannabis, LSD, chocolate, sex, and of women with men.

The new consensus advocating equal opportunities for drugs and women, however was short-lived. Epidemiological research began to demonstrate the exponential relation of alcohol-related-harm with per capita consumption of alcohol (Ledermann 1956); and further that the consumption of alcohol was "socially contagious" - it had a snowball effect (Schmidt 1977) which further exacerbated the exponential rise of alcohol-related harm. In particular, women were especially harmed their consumption of alcohol due to their physiological composition (De Lint & Schmidt 1971, Schmidt 1977, Shaw 1980, Wilkinson 1980, Ferrence 1980, Breeze 1985). Consequently, the notion of women's equal capacity for leisure/pleasure with men was belied by the reaffirmation of their organic need for abstinence. The liberal institution of equal opportunities for women and for alcohol was exposed as a socially atavistic

measure; and social reform at the level only of the economic (eg through reducing taxes on alcohol, equalising women's wages with men) was demonstrably harmful in term of the bio-cultural dialectic. The way forward therefore was to concentrate reform at the level of the social (in terms of morality, or the "social conscience").

Chapter five is concerned with the organic assumptions informing much sociological thought on drunken women. In explicating this, it illustrates the construction of abstinent femininity through psychoanalytic, psychological and functionalist sociological discourses. In particular, the tenacity of the classical rationalist organic analogy is clearly evident: Durkheimian sociology posits more than a bio-cultural dialectic, it posits a bio-cultural hierarchy wherein the 'freer' an individual is of her/his bodily demands, the 'freer' s/he socially is.

Specifically women, in their organic reproductive capacities, are conceived as more "bodily enthralled" than men, and thus not suited for responsible public activity. The epidemiological observations of women's greater than exponential

rate of harm through the consumption of alcohol evidences this. Thus social dis-order, such as the inorganic/dysfunctional imposition of equal opportunities is experienced at an individual level. Individual dis-ease as a result of social dis-ease/pathology is therefore experienced as a bio-cultural fact.

Furthermore, dis-ease (social or individual) was not conceived as gender-neutral. Human (social and individual) health was conceived in the seventeenth and eighteenth centuries in term of capital abstinence - consumptive inabstinence was pathogenic; by the late nineteenth century, however, inabstinent consumption was seen as necessary for health: the repression of essential human nature through twentieth century consumption was is seen as positively carcinogenic (Sontag 1978). However, as the expression of essential "human" nature through leisure/pleasure is denied to women through their functional definition as abstinent, so too is their achievement of 'health'. In their "bodily enthrallment" women's are conceived as intrinsically sicker than men (Gove & Todor 1974, Dunnell & Cartwright 1972,

Cooperstock 1972, 1975, 1977, Nathanson 1975, Reid & Wormals 1981, Kessler et al 1981, Brannen & Collard 1982); but also in striving to wriggle free of their "bodily enthrallments" in the active pursuit of collective public activity leisure/pleasure, women risk even greater sickness (Smart 1976). This is tautologically evidenced not only in the epidemiological data, but also in women's greater social presence in doctors surgeries (Cooperstock 1975, Room 1972). In their formal definition as sick by doctors, women's are relieved of the necessity to pursue collective public activity; and in their consumption of prescribed (often) psychotropic drugs their organic dependence upon men for gratification is satisfied: in swallowing the pill they swallow the law of the father. Women's dependency, therefore, is amplified in their expression of dis-ease.

Women's consumption of alcohol, similarly provides no respite from the constraints of their dependency. For men 'normal' drinking defines their independent masculinity through their participation in pub culture: their collective engagement in waged labour is symbolised through

their alcohol consumption in 'rounds'(Dorn 1983), and their leisure is expressed through their consumption of women in the pub (Hey 1986). Women however, insofar as they engage in pub(lic) drinking in sexualised terms experience no such leisure. Women's opportunities for collective leisure/pleasure is censured (Leonard 1980, Whitehead 1976)insofar as it threatens patriarchal access to women's as the key means of expression. And lacking the collective means for leisure/pleasure, inabstinent women are caricatur ed as sexually promiscuous and/or pathetically dependent (Otto 1979, 1981). Either way, the stereotype provides for a re-enforcement of patriarchal access to women: in the form of paternalistic welfare intervention or of explicitly sexual violence.

Health and welfare intervention in women's drunkenness is similarly susceptible to such stereotypes, informed by it's psychoanalytic and psychological legacies. Consequently, drunken women remain largely invisible - until they begin to fail in their functional maternal roles, or experience a chronic degree of alcohol-related ill

health. In terms of the latter, the invisibility of drunken women may be regarded as a form of institutional violence (through neglect) against women. Health and welfare agents tend to be blind to characteristics of drunken women that do not conform to their functional maternal roles (Isaac & Moon 1985, Isaac 1986). Consequently, much intervention is in term of feminine rehabilitation. Women, for example, are often required to attend treatment programmes in order to regain or maintain custody of their children; and treatment programmes themselves are often in terms of women's adjustment to their organic role.

The 'blindness' of health and welfare agents, however, provides some degree of 'freedom' from social intervention for inabstinent women. For so long as they can remain "non-descript" (Worrall 1990), not 'fitting' any welfare categorisation they can explore inabstinence. However, such explorations are usually individualised, haphazard, and often result in women physical/sexual harm either through their neglect by welfare agents, or through explicit patriarchal censoring of their activities.

Chapter six discusses the implications of this in terms of sociological research: through sociology's striving for positive results (reliable or valid), the sociologist is required to "bifurcate" herself from social/material life (Smith 1977). In this way sociology acquires a textual "conceptual currency" (Smith 1977) into which the material actualities of what people are doing in society are transmogrified. Thus sociology administively constructs living issues into discrete phenomena - 'problems' that are to be managed within the research context alone at first, but as research effects social policy and the nature of social welfare intervention, these sociologically defined problems are managed within the "actual practice of government".

From this standpoint, I embarked on my field-work research concerned to avoid such administration of my 'data'; and to such an effect I use direct quotations extensively. However, mindful that "our data will not arrange themselves" (Coyner 1983), I was also concerned that my standpoint as a feminist social researcher concerned with the

social control of women was clear to all the people that I spoke to during my field-work, and also in my account of my field-work.

My first research interest was in the processes and experiences through which women come to be 'alcoholic'/'problem drinkers'. In meeting with such women and with drug and alcohol agency workers, I discussed this issue with all parties, and gradually built up a picture of the social processes effecting women's drinking. With regard to the agency workers, I was immediately struck by the significance of gender on their perceptions of women's drinking and drunkenness. Of the 20 workers whom I spoke to, out of 11 men, eight held explicit organic/functionalist views of women's drinking, such that drunken women essentially more pathological and more obdurate than men, and that "alcoholism is the ransom of emancipation" (Appendix 6, Table 1); only 2 out of 9 women held such views. Alternatively, women workers were far more likely to express a more radical standpoint on women's drinking (8 out of 9 interviewees), feeling that processes of the social control of women, such as domestic isolation and the

intervention of health and welfare agents (such as themselves) accounted for most of the drunken women they encountered in their professional capacity (Appendix 6, Table 1).

Most of the women administratively defined as 'alcoholic'/'problem drinkers' similarly felt that women drank more to cope with the enforcement of their social isolation, than as an expression of their liberation: most of them were painfully aware of the risk of sexual/physical violence/damage through their drinking, and related this to issues of the social control of women (Appendix 6, Table 2c). Furthermore, the women I spoke to were also clearly aware of the role of health and welfare agents in controlling their activities, 1 in terms of their roles as mothers. Some clearly resented this, and actively rebelled by continuing to drink whilst attending the prescribed treatment programme; however, most were effectively compelled to remain abstinent in order to maintain custody or access to their children. The one woman (Rose) who had never had children or been married was clearly "non-descript" (Worrall 1990) in her failure to 'fit' the administrative categories of

health and welfare agents: she was unequivocal in her persistence in drinking through her 'treatment', whilst simultaneously recognizing her subjection to a significant degree of sexual and physical violence. She did, however, express her liking for her agency workers, who were women, and who provided some level of political/enabling support. In this both Rose and her workers were unusual as the organic/functionalist analogy was evident in the workers perceptions of causes of drinking problems in women.

The women I spoke to were generally well aware of the processes of social control of women, in particular, the role of health and welfare agents and the threat of sexual/physical violence. In particular, the functional definition of women as mothers as particularly effective in enforcing women's abstinence - both from collective public activities, and from alcohol. Significantly, in accordance with the wider clientele of the health and welfare services, all of the women I spoke to came from working class backgrounds, some experiencing a considerable degree of impoverishment, from which alcohol provided some

temporary, illusory respite. And while the women I spoke to generally resented the coercive intervention of the health and welfare agents, feeling powerless to rebel against it, most of them welcomed the alternative respite that such 'treatment' provided.

While formal health and welfare intervention in women's inabstinence must be regarded as a means of maintaining the patriarchal control of and access to women, it must also be seen as the product of reformative struggle. Drunken women themselves feel the need for some support as they caricaturise the dependency that defines contemporary women; and health and welfare workers often have a clearly critical view of the institutions describing the scope of their activities. The form of health and welfare intervention in women's drunkenness, therefore, must be regarded as the result of many and varied struggles. The influence of the organic analogy through psychoanalytic, psychological and sociological discourses, however, is such that intervention in women's inabstinence is usually in the form of feminine rehabilitation. Although many

of the agency workers with whom I spoke were concerned to enable women to achieve active leisure/pleasure, they were all working within a context that prioritised women's maternal role. As such, many of the drunken women that they encountered were ascribed the status of client/patient in order to maintain or regain custody of their children. Successful treatment therefore, was defined in terms of successful conformity to the abstinent role of the organic mother.

The possibility of women's sober inabstinence, in terms of their active pursuit of pleasurable and public activities is inhibited, therefore, socially and materially. The women whom I spoke to, although administratively defined as deviants, expressed the parameters of the social control of any female inabstinence. So long as women remain dependent, in economic and emotional terms, on an individual and a social level, their activities will remain approved. When a woman begins to engage in independent activities, in a domestic or a public arena, she will begin to experience penalties - the loss of her children, the risk of

violence or harm - that cut across the boundaries of the economic and emotional, the private and the public.

CHAPTER 1: ABSTINENT DIVISION

When the French philosopher, d'Holbach remarked in 1770, that "Man is unhappy because he is ignorant of Nature", he expressed the main tenet of the ideas of the Enlightenment. Nature was conceived as a single system comprising a continuum of phenomena in Enlightenment thought, replacing the classical belief that explanations should be sought in the revelations of God. Divine (or Supernatural) Will simply inhibited what were seen as the fundamental aims of Man¹ - happiness and self-preservation, since the notion of some qualitatively different God inhibited rational human inquiry and the consequent human acquisition of knowledge. The conception of a fundamental continuity between all natural phenomena, between humanity and the rest of nature, allowed for the explanation of all phenomena in terms of the organisation and activity of matter.

This 'obvious and simple system of natural liberty' was articulated by Smith (1776). He

conceived the relationship of (equal) individuals to the social organisation as a Contract, involving the free consensus of individuals joining together to create a civil society. Smith based his conception of society on a study of the market, which he saw as involving free and equal individuals rationally contracting their labour on the free market in the pursuit of productive activity, which he saw as the essence of value. Through the social contract, therefore, human labour (as rational, productive human action) was the only source of value in the economy (Ricardo).

According to this argument, social wealth and thus welfare depended on the individual to freely pursue his own interests, so "long as he does not violate the laws of justice". Smith (1776) argued that the unintended consequences of this intentional action are that the individual

".. frequently promotes [the interest] of the society more effectually than when he really intends to promote it."

Social welfare was, according to Smith, the latent function of the free market.

In identifying value exclusively in productive labour, the rising bourgeoisie denied the feudal conviction that the rights of man were derived from and limited by their estate, class, birth or lineage. The rising radicals, proclaiming rational equality and demanding democracy attracted considerable concern. The old aristocracy grew increasingly sensitive to the dangers of public gatherings. Alehouses, as usual venue for community gatherings became a key focus of concern (Dorn 1983). 1495 saw the first statute relating the selling of alcohol to community congregations; it sent the leaders of "unlawful assemblies" of 40 or more, and of "political agitation" to prison for an unspecified "long time". A further Act in 1549 made it treason for 12 or more people to publicly agitate for change; and an Act in 1571 was designed to discourage all games, plays and entertainment that may have provided a focus for public gathering (Dorn 1983).

By 1606 public drunkenness was legally defined as a criminal offence: the 1606 Act was passed in order to "repress the odious and loathsome Sin of Drunkenness". Furthermore, "the overthrow of many

good Arts and Manual trades, the disabling of drivers, workmen and the general impoverishment of many good subjects" was attributed to the power of Drunkenness. Four further Acts of the seventeenth century established drunkenness as indeed an odious quality: in 1635 an Act was passed "for the better repression of Drunkenness"; 1644 saw the outlawing of all leisure pursuits on Sundays, with particular reference to drinking; a 1647 Act made it illegal for "scholars, apprentices and servants" to stay in inns after 8pm; and by 1650 it was illegal to enter any place which sold or served ale on "Lords Days, Days of Thanksgiving of Humiliation" (Dorn 1983).

However, as the Utilitarian principles of freedom and equality gained in strength and the potential of capitalism began to be realised, the ascribed power of the landowners became increasingly untenable. And the institution of laws beneficial to relatively few powerful men came under increasing pressure. Smith's rational conception of 'natural liberty' was extended to moral matters in Bentham's (1789) assertion that actions were adjudged morally right or wrong according to

whether they maximise pleasure (thereby minimising pain) among those affected by them. Thus the aim was the 'greatest happiness of the greatest number'. Here the assertion was that since Nature is neutral, Man is born neither good nor evil, but malleable by education and experience. Thus eighteenth century Enlightenment provided for the development of moral systems determined by what is useful to society: the power of man over man is justifiable only in terms of utility, not in terms of the passions of rulers. And the responsibility of the State in this climate was simply to facilitate natural morality: so long as the individual acts rationally, he will be within the laws of moral justice. Furthermore, the notion of a continuum of individuals provided that each was equally capable of exercising rational influence on the overall system - a natural and democratic rationality replaced classical metaphysics.

The equality of individuals therefore, was premised on the assumption of the rationality of human Will, expressed in self-interest. The maximisation of individual self-interest - or 'happiness' - therefore engendered a natural

social order, expressed in the Social Contract. The 'obvious and natural' rationality of the utilitarian Social Contract provided effective and consensual social control: social disorder was conceived as the expression of essential inequality. Thus insofar as disorder was irrational in damaging the utilitarian social order, it expressed inhuman irrationality. And the development of the utilitarian consensus regarding the essential rationality of human individuals provided the means for the landowners to compromise on issues of bourgeois interest.

By the mid-eighteenth century the privileges of the aristocracy were reduced and the franchise was marginally widened to include the 'respectable' working class. Prison control and law enforcement were taken out of the hands of Justices of the peace and handed over to state control. However, as rational utilitarian equality was established through the institutions of the State, the reality of material inequality became increasingly evident. The problem was that the rational deduction that all individuals were free and equal insofar as they engaged in rational productive

activity, namely the pursuit of Value, did not concur with the material interests of the bourgeoisie:

"The middle class never believed that it's property - derived incomes - its rights to rents, profits, interests - were justified in terms of the utility of property. The middle class insisted that property and men of property were useful to society and deserving of honour and other rewards because of this; but men of property also held that property was sacred in itself, and, in doing so, made a tacit claim that its rewards should not depend only on it's usefulness. The property interests of the middle class have thus always exerted a strain against it's own utilitarian values" (Gouldner, 1971, p.71).

As the reality of social disorder was evident in the growing incidence of theft, the contention that such expressions of inequality were proof of essential inhumanity became increasingly untenable. In 1804 Beccaria observed that theft

"... alas, is commonly the effect of misery and despair; the crime of that unhappy part of mankind, to whom the right of exclusive property (a terrible and perhaps unnecessary right) has left but a bare existence" (Beccaria 1804, p.80)

As theft was unequally distributed through society: concentrated amongst the materially impoverished sectors of society, Beccaria rationally deduced that it was a latent function (like social welfare) of the free market. Furthermore, as there was a clear reason for theft

- namely poverty - Beccaria concluded that it could not be regarded as irrational: theft, by this analysis is an exercise of natural moral justice. The problem for the State, however, was that the Social Contract provided no justification for intervention in the natural workings of the market, that, Beccaria observed, rationally caused theft.

Drunkenness was also observed to be unequally distributed throughout society, despite utilitarian faith in the free rationality of the market. The 1736 Gin Act raised taxes on spirits in the first attempt to control the individual consumption of alcohol by intervening in the free market in order to encourage social discipline through price. The Act noted that

"whereas the drinking of Spirituous Liquors or Strong Water is becoming very common, especially among the people of lower and inferior Rank, the constant and excessive use thereof tends greatly to the Destruction of their Healths, rendering them unfit for useful labour and Business, debauching their morals, and inciting them to perpetuate all manner of vices".

However, the market discipline of price resulted only in public riots, and, unfortunately, the

Social Contract did not allow for utilitarian intervention in public riots.

In 1848, however, Mill (1921) expressed the theoretical solution to the dilemmas of the Social Contract. In drawing a distinction between the activities of production and of distribution/ /consumption Mill began to move away from Ricardo's labour theory of value. His argument was that the value of a product comprises not only the labour required to produce it, but also capital investment in the means of production:

"In our analysis .. of the requisites of production, we found that there is another necessary element besides labour. *There is also capital; and this being the result of abstinence*, the produce, or it's value, must be sufficient to remunerate not only the labour required, but the abstinence of all the persons by whom the remuneration of the different classes of labourers was advanced. *The return for abstinence is Profit*" (Mill 1921 pp 461-462 my emphasis).

In this way, then, Mill allowed for the continuation of the principles of equality and freedom within the sphere of production, which was rationally in the interests of the social good. However, he asserted that inequality prevailed within the arbitrary and irrational realms of distribution; and further, that *inequality was the*

result of the differential operation of individual abstinence. Therefore, in distinguishing between the spheres of production and distribution, Mill recognized that the market could not, by itself, provide social justice: additional moral factors were forces to be grappled with in the resolution of social ills. So he agitated for socialistic intervention within the sphere of distribution funded through the exercise of capital abstinence: namely the philanthropic contribution of money to fund such welfare interventions².

The role of the state developed beyond merely ensuring the rational production of value (capital), to include the regulation of the distribution of value in the pursuit of the Greater Good. The dilemma over utilitarian intervention in rational theft was resolved, and the concerns of the old regime over public gatherings and public drunkenness were dealt with on two counts. The Metropolitan Police Act (1829) established the police force, and the Beerhouse Act (1830) removed the monopoly of the magistrates in the licencing of Public Houses, thereby introducing free trade into the Brewing Industry.

Control shifted from the social circumstances of drinking to a reliance on the workings of the market to regulate individual drinking circumstances backed up by non-economic incentives to conformity: policing.

In removing the licensing monopoly of the magistrates, the Beerhouse Act (1830) met concerns over the excessive consumption of Gin by again increasing the duty on it - but this time the police force was established so as to maintain public order - providing an opportunity for more incorrigible individuals to learn morality, since "the moral facilities, like the body, become developed only through use". Capital abstinence provided the means for public policing, and public policing, in turn, ensured public abstinence from drunken disorder.

The 1830 Act also facilitated the growth of a plethora of small brewers, who, in their rational self interest, competed for a share of the alcohol market; and in doing so served the greater social good by encouraging drinkers to switch from more expensive "spirituous liquors and strong water" to

milder beer. The expansion of the alcohol market thus provided the opportunity to drink freely within market controls, within licensed premise; and, accordingly any opportunity to consume alcohol outside of the framework of the market became morally suspect.

"Temperance reformers argued that the expansion in the retail trades, from which many of them drew their livelihood, had superceded the commercial role of the fair .. [which was now] 'not for the transactions of business of any kind, but merely for what is called pleasure, alias drinking'.." (Harrison 1971, p.328).

The State had liberalised controls on drinking in order that it (public drinking) could operate as a "transaction of business": drinking was exclusive to the realms of business - to be done only within the public house, where it was subject to the scrutiny of the market. Drinking for reasons other than business became phenomena to be dealt with by the State through intervention in the sphere of distribution - such as policing. Alcohol was thus commodified: the social/political content of drunkenness as a threat to the rational social order was transmogrified through the enforcement of capital abstinence through taxation into the expression of the social good of the market.

The development of the alcohol industry was part of the general movement away from small scale production within the household, and with it, the opportunity for women and men to co-operate as independent petty unit, owning the means and production and selling the product (such as beer) on the market. By the eighteenth century women, hitherto workers equal with their husbands, faced an employment crisis. As journeymen remained with their masters as freely contracted waged labourers, the work of women was excluded from the family business (Foreman 1977). And, in the rational production of surplus value, 'non-productive'³ wives were either reduced to a state of economic dependence, or else 'free' to engage in waged labour.

As the economy expanded and the demand for labour increased, employers made more use of women. Not only were women valuable as a source of cheap labour (especially if unmarried or widowed), but, as the working class gained collectively in strength, the historically weak position of women was used by employers as a strike-breaking force. Consequently, working class men began to pit their

strength towards excluding women from the labour market, rather than improving women's pay and conditions alongside those of men. The growing strength of the Trades Union Movement in the first half of the nineteenth century, and the move away from labour extensive to labour intensive forms of production with the accordant rise in competition for jobs, resulted in a series of Factory Acts. Rhetoric had it that these Acts would improve women's working conditions, however, since the legislation only covered those areas of employment where women competed with men for jobs, such as textiles, their main effect was to protect traditional⁴ male employment and establish the family as distinct from production:

"Many working women had been demoralised both by their conditions of work and the hostility of their fellow workers. The disintegration of the working class family, as wives and children went out to work and its members moved to different parts of the country in search of work, was seen by the majority as part of the attack of the ruling classes on their way of life. Thus the protection of the family and the securing of women's place within it was regarded as integral to the fight against the employers and the brutalising effects of working conditions. *And gradually the ability of the worker to keep his wife at home became a sign of working class strength, of prosperity, of better days to come*" (Foreman 1977, p.92, my emphasis).

While Ricardo identified labour as the only source of value, the growing contradiction between the utilitarian rhetoric of equality and the material reality of inequality provided the means for the institution of two distinct, but related realms of production and distribution. And Mill ensured that abstinence in the realm of distribution was also a source of value. Society was now legislatively realised as a system comprising two *different* but *interdependent* parts. The problem of social order was now not simply to ensure the extension of market forces to the total organisation; rather it was the articulation of the relationship between the parts of the social organisation. The relationship between capital and labour was articulated in the employment contract and expressed in the wage form. Now, with the identification of the sphere of distribution, the problem was the articulation and expression of the relationship between this and the sphere of production. In the absence of any such articulation the utility, or value, of this alternative realm was questionable.

The transmogrification of mastercraftsman into capitalist allowed for the creation of value through the abstinence of the wife from work, in enabling the capitalist to invest in the means of production, thus serving the interests of profit and the common good (since investment provided employment). Working class women, however, had no such opportunity to produce value⁵: their only value was their labour power. But as the nineteenth century progressed and the strengthening Trades Union movement defined labour power as a male capacity, the capacity of women was simultaneously defined as domestic. The bourgeois value articulated in the marriage contract and expressed in an abstinent wife was generalised to the working class.

"When the support of the family depends, not on property, but on earnings, the common arrangement, by which the man earns the income and the wife superintends the domestic expenditure, seems to me in general the most suitable division of labour between the two persons... In an otherwise just state of things, it is not, therefore, I think a desirable custom that the wife should contribute by her labour to the income of the family... Like a man when he chooses a profession, so, when a woman marries, it may be understood that she makes a choice of the management of a household, and the bringing up of a family, as the call upon her exertions, during as many years of her life as she may be required for the purpose: and that she renounces, not all other objects and

occupations, but all which are not consistent with the requirements of this" (Mill 1965, p.237).

Increasingly marriage became the only legal option for women's economic survival (Dahl and Snare 1978): whilst the wage contract was the main source of survival for men, so too was the marriage contract for women. As the man sells his labour on the labour market, the woman sells her sex on the marriage market; and the freedom of men in the market depended in essence on the confinement of women in the home. Thus, for the time being, the marriage contract secured the articulation of the realm of rational valuable production with the realm of abstinence from rationality, and defined the utility of qualitatively different individuals. Thus the development of commodity production in the interests of the social good of profit was materially based upon the ideological confinement of women within the sphere of the domestic: the market freedom of men depended in essence on the confinement of women at home.

The early participation of women in the Social/Labour Contract therefore allowed for the conception of women's essential equality with men.

The rational assumption of human equality in rational productive activity, however, faced a growing contradiction as women's participation in such activity caused intensifying social disorder. And the extension of the franchise to 'respectable' working men and the rising strength of the Trades Unions as the nineteenth century unfurled led to the exclusion of women from valuable social activity (Walby 1990). Women's membership of rational society was granted only in the expression of their essential difference from men in the exercise of their will in abstaining from waged labour. Insofar as women did not abstain from such public productive activity they failed to demonstrate their human will, and as sub-human, atavistic creatures were denied individual human rights. Thus women who failed to abstain were conceived as lacking in human will and disqualified from membership of rational human society: they were required to fight for their survival amongst the 'unrespectable' working men, liable to sexual and physical violence.

Thus Mill, despite his concerns for the political liberation of women, defined value in bourgeois

abstention, and by the end of the nineteenth century women were valuable only to the extent that they were abstinent.

"The leading characteristics of femininity were abstinence - both abstinence from labour and abstinence from sexuality - and reproductivity, that is, the production of children. 'The functions of the wife', went one formulation, 'except among the poorest class, are or ought to be exclusively domestic.' That meant she should 'bear children, regulate the affairs of the household, and be an aid and companion to her husband.' Her social importance lay in her very idleness. Non-productivity was a major indicator of class standing, a working wife a sign of social and economic disaster" (Fee, 1976, p.176, my emphasis).

Women's abstinence, then, was material in terms both of sex and labour. Women were conceived materially as qualitatively different from men. And the material reality of inequality, through the ownership of private property, extended to the ownership of the abstinence of women within marriage. The abstinence of women materially embodied the freedom of individual men.

Thus, by the nineteenth century, women's economic dependence on men was established; their abstinence from waged labour necessarily required thier abstinence from legitimate (ie public) drinking and women's inabstinence in seeking waged

labour and/or in drinking, was increasingly identified with women's sexual inabstinence. Although up until this time women's participation in the Alehouse was strictly regulated by social convention,

"... attitudes towards female accessibility to the pub were not necessarily constant [they nevertheless] would have fluctuated with the more general attitudes .. towards the Alehouse as a centre of sexual encounters." (Hunt 1986)

Furthermore, since women were involved in the production of ale and in working in the Alehouse, restrictions on women's drinking in public were less than effective: the Alehouse and alcohol were part of general everyday life. However, as alcohol and drinking became confined to business activities, so too was it increasingly excluded from the non-productive sphere of the family, where the true woman would embody the "purer side of human nature, uncontaminated by the baseness of worldly affairs" (Levine 1980). The pub became the antithesis of the home

"... the bastion of maleness, where men escaped from wives and family responsibilities... The radical split between home and society and between men and women meant that some territorial and symbolic areas were exclusively male... The saloon was .. a competitor of the home and a direct attack on the morality and values that the home was thought to represent... enshrined

and sanctified in the home, women were quite literally disrobed in the saloon." (Levine 1980, p 40-41)

And,

"The alliance between publican and prostitute was natural: the publican presided over a meeting place where human relations of all kinds were established, sold a powerful solvent of barriers between individuals, and was generally associated with recreational gaiety." (Harrison 1971, p50)

Inabstinent women thus became a form of male recreation: by drinking in public (houses) women were rendered available to all men: abstinence ensured a woman's private availability to one man - her husband; inabstinence made women publically available to men. The association between women's capital inabstinence and their sexual inabstinence effectively sanctioned women's inabstinence in general (by threat of rape) and further, the (sexual) consumption of inabstinent women domesticated them.

The ideological^a distinction between the spheres of production and distribution provided money with an instrumental value rather than an existential value: whilst Smith believed that essential human nature was realised through rational productive activity, and money was an expression of that essential human nature, liberal reformists, such

as Mill, believed that essential human nature was expressed in the distribution, rather than the production of human goods. Thus money, rather than expressing the individual *per se*, became a means of expressing self. Thus the decision as to whether to exercise abstinence or to purchase pleasure became a matter of the exertion of individual will, occasionally informed by institutional sanctions such as taxation and policing. And as the means of self-expression, or 'pleasure' were only available through "the credit card of work" (Young 1971), women's willful self-expression was limited to abstinence. Women thus held the key to the moral substance of society: they provided the necessary check to the unbridled purchase of pleasure, and thus provided the means of articulating social production with social consumption.

Thus the spheres of production and consumption were articulated through legitimate leisure (self-expression) insofar as it is purchased through waged labour and capital abstinence facilitated by fiscal policies (such as alcohol tax) and the possession of an economically dependent wife. The

reformist institution of separate spheres, therefore, required women's abstinence from waged labour through the exercise of their will. Only in this exercise of their will could women claim freedom from widespread social sanctions - from the risk of physical attack in their disordered attempts to gain entry to gainful employment (Chapters 5, 7 & 8) (Walby 1990). Furthermore, women's abstinence from waged labour necessitated their economic dependence upon men, instituted in marriage. And women's marital abstinence ensured their private availability to their husbands: through the marital enforcement of women's abstinence, their husbands exclusive right of access to them was established. Insofar as women failed to be abstinent - either by refusing marriage or refusing their husbands absolute access to them, women were conceived as beyond the realms of civilisation. Such inabstinent women provided a threat to the substance of society: insofar as they refused to abstain from pleasure themselves, and insofar as women's self-expression denied men access to rational (namely marital) means of their self-expression, unabstinent women were subject to the violent expression of men - in

rape and sexual violence - and as the nineteenth century progressed, to paternalistic rehabilitation.

So by the end of the nineteenth century, the economic dependency of women and their increasing sexual vulnerability in public required their contractual abstinence (marriage). And, as liberal reforms allowed for the intervention in activities of individuals who deviated from the rational laws of human interaction, those women who failed to act with reasonable utility became subject to State sanctions.

Enlightened means of dealing with those inhuman creatures who failed to see reason was to confine them: to situate them both physically and conceptually beyond the realms of rational humanity. Houses of Confinement (Foucault 1965) were built throughout Europe to contain

".. beggars and vagabonds, those without property, jobs or trades, criminals, political gadflies and heretics, prostitutes, libertines, syphilitics, alcoholics, lunatics, idiots and eccentrics .. rejected wives, deflowered daughters and spendthrift sons" (Doerner 1981, p.15).

An heterogeneous assortment of creatures, subject to all manner of various contemporary definitions, with one thing in common - their inability or unwillingness to enter into either the wage contract in the case of men, or the marital contract in the case of women - were isolated (in the greater social good) from market forces.

By the beginning of the end of the eighteenth century, however, Millian principles of philanthropic intervention provided the intellectual capital for revising the Enlightened conception of such inhuman creatures.

The reformist view held at the centre of the social world "adult, sane individuals .. seen to be fully responsible for their actions" (Taylor, Walton and Young, 1973). However, there were other individuals who were "seen to be incapable of adult freedom of action" and "less capable of making accountable decisions"; and whom were identified as "children and (often) the aged" and "the insane and grossly feeble minded". For individuals with these characteristics, the liberalist reformers allowed that they could not

be 'free' and thus responsible; their actions are determined.

Those individuals, then, who deviated from the rational laws of human interaction to irrationally engage in non-productive, non-abstinent (non-valuable) activities, were conceived in one of two ways. They were either succumbing to their irrational impulses by choice, since they were as free as the next individual to choose either rational or irrational activities. Or else they were the victim of factors which militated against their free exercise of rational choice, such as extreme youth or extreme age or clinical madness. In short, such individuals were conceived as either 'mad' (as having no choice) or 'bad' (as having deliberately chosen to engage in irrational behaviour). Either way, deviance was regarded as irrational, and thus less than fully human behaviour. And arguably, this two pronged model of deviance has remained ever since.

"A central consequence of this revision was that punishment came increasingly to be phrased in terms of punishment appropriate to rehabilitation... however .. choice was (and still is) seen to be a characteristic of the individual actor - but there is now a recognition that certain structures are more conducive to free choice than others"

(Taylor, Walton and Young, 1973, p.9, their emphasis).

Thus, the ability to exercise free choice was seen by the reformists as, to a certain extent, an environmental rather than an individual question.

The shift was from an Enlightened concept of the rational individual as possessing considerable knowledge of his action to that of an individual motivated by more profound causes, unperceived by the conscious. The mood had shifted by the nineteenth century, from rational deduction to empirical observation. And along with the mood, the principle of the fundamental equality of individuals, rationally engaged in essential human activity, was replaced by the fact of human inequality, wherein individuals were free and equal in so far as they exercised their conscious will in their application to rational activity. Those who failed to exercise their conscious rational will were either willfully, consciously engaging in socially damaging behaviour, and should be punished; or else subject to forces beyond the intervention of their consciousness - forces either causative of or symptomatic of "certain structures", such as society or

individual psyche, that induce such irrational deviance.

Therefore, the mad - as subject to forces beyond their control - whilst hitherto were

".. regarded as unfeeling brutes, ferocious animals that needed to be kept in check .. were now seen instead as sick human beings, objects of pity whose sanity might be restored by kindly care" (Showalter 1987, p.8).

And they came under new scrutiny by social reformers who began to create alternatives to the madhouse the workhouse and the prison: asylums. Physical coercion and force was replaced by paternalistic rehabilitation and surveillance.

Insanity came to be regarded as an affliction of the highly civilised, as it required the bifurcation of society (production/consumption) and also of the individuals comprising society (conscious/unconscious). As Dr. Andrew Halliday explained

"We seldom meet with insanity among the savage tribes of men... Among the slaves of the West Indies it vary rarely occurs .. the contented peasantry of the Welsh mountains, the Western Hebrides, and the wilds of Ireland are almost free of this complaint" (Halliday, 1828, quoted in Showalter 1987, p.24).

And consequently, as the richest and most advanced society, England had the highest incidence of insanity. However, as rational abstinence provided the means for articulating the spheres of production and consumption, and as women provided the substance of that articulation, a particular and increasingly prevalent form of madness became evident. The 'female malady' was associated with the sexuality and essential nature of women (Showalter 1987).

The discovery of the "brutal mistreatment" of women in the Enlightened madhouses led to the liberalist "lunacy reform movement". And while public opinion held that madmen were subhuman creatures requiring violent restraint (Scull 1982), the discovery of the abuse of these "delicate" women inspired a public outrage, culminating in a series of legislative reforms. The 1828 Madhouse Act was designed to control abuses of commitment to asylums, and established that the commitment of private patients to asylums required a certificate signed by two "medical men", and the commitment of pauper patients required signatures of 2 magistrates or of an

overseer and clergyman of the parish, plus a signed medical certificate. The medical definition of the mad was firmly implemented. And the public responsibility of the hitherto inhuman realms beyond the market was realised not only in the Metropolitan Police Act of 1829, but also in the 1845 Lunatics Act, requiring all counties and principal boroughs to make provision for the care of (poor) lunatics. Within two years 36 out of the 52 counties (in England and Wales) had built public asylums.

By the middle of the nineteenth century, the treatment of madness was primarily by domestication. This involved not only "reassimilating madness into the spectrum of recognisably human experiences", but also restructuring treatment in domestic terms. The organisation of public asylums was modelled on 'the family'. The roles of father and mother were assumed by the resident medical superintendent and his wife, with attendants designated as older brothers and sisters and patients as children. Discipline was maintained through paternalistic authority - as in a family. In celebration of

women's domestic role, and the recognition of their essentially abstinent nature, the Victorian Reformers made their asylums "homelike". And, in doing so, domesticated the fantastical properties of Enlightened madness.

While the correlation between madness and the wrongs of women not only provided the impetus to reform,

"The victimised madwoman became almost a cult figure... [this] gentle female irrationality, so easily subjected to male reason, might also represent an *unknowable and untamable sexual force*" (Showalter 1987 p.10, my emphasis).

Showalter (1987) describes the theme of escape from material femininity (abstinence) into the inabstinent femininity of insanity running with fascination throughout the literature of the mid-nineteenth century. The ambiguous nature of female madness was seen increasingly as requiring management in order to tame and domesticate it and bring it within the sphere of rational abstinence. Thus, as the proportion of women asylum inmates steadily increased throughout the nineteenth century

".. the dialectic of reason and unreason took on specifically sexual meanings, and the

symbolic gender of the insane person shifted from male to female" (Showalter 1987, p.8).

Psychiatric theory developed to redefine madness, not as 'loss of reason', but as deviance from socially acceptable behaviour: "moral insanity" was defined as

"a morbid perversion of natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect, or knowing and reasoning faculties, particularly without any insane illusion or hallucination" (Prichard, 1838, quoted in Showalter, p.29).

This symptomatology was not all that different from the characteristics of the inmates of Houses of Confinement described by Doerner (1981, above). And is general enough to extend to almost any kind of behaviour construed as abnormal or disruptive. Furthermore, the causes of remaining traditional categories of madness, such as mania, dementia and melancholia, were also attributed to such immoral inabstinence.

"Speaking generally .. the causation of insanity everywhere, special organic disease apart, is an affair of the three Ws - worry, want and wickedness. It's cure is a matter of the three Ms - method, meat and morality" (Granville 1877, quoted in Showalter p.31)

However, Victorian theories of causation were far from consistent. The ascent of the Positive Sciences inspired the Medics in their search for

the physical causes of insanity; but, in practice, they had great difficulty in distinguishing between moral and physical causes. Women were particularly ambiguous. Conolly (1858) saw in the face of an 'alcoholic'

".. the painful questioning of a woman not forgetful of her former life, nor unconscious of the comfortless change that has come over her.."

And in another,

".. the bloated face .. and large lips .. the disordered, uncombed, capriciously cut hair [and] indolent position of the body .. [showed] a woman of low and degraded life, into whose mind, even before madness supervened, no thoughts except gross thoughts were wont to enter" (Conolly 1858, quoted in Showalter 1987, p.94).

The rapidly rising numbers of women entering the asylums was held as proof that women were more vulnerable to insanity than men. And the doctors sought to explain this predominance in the "biological crises" of women. The instability of women's reproductive systems was seen as interfering with their sexual, emotional and rational control; and the connection between women's reproductive and nervous systems was discovered to be subject to a "reflex", or "special law", rendering them the "victim of periodicity". If the woman was unfortunate enough to

be mad, it was explained as "reflex insanity" (Storer 1871 in Showalter).

Whatever the cause, nonetheless, Victorian doctors believed that the solution was to exercise will-power and avoid excess:

"He who has given a proper direction to the intellectual force, and thus obtained an early command over the bodily organ [the brain] by habituating it to processes of calm reasoning, remains sane amidst all the vagaries of sense; while he who has been the slave, rather than the master of his animal nature, listens to it's dictates without question even when distorted by disease - and is mad" (Barlow 1843, quoted in Showalter 1987, p.30).

Thus the treatment of madness was "moral management", involving the re-education the insane in the habits of "industry, self control, moderation and perseverance".

Insofar as madness was defined in inabstinence, its cure was in the rational enforcement of abstinence. The rationale was that

".. treating the patient like a rational person .. was the best way to cultivate the sense of self-esteem that would lead to self-control" (Showalter 1987 p.31).

With regard to women, the treatment task was to preserve "brain stability" in the face of overwhelming physical odds. This required, firstly, the management of women's periodic cycles

and sexuality; and second, the introduction of the qualities of abstinence that would help her to resist the stresses of her body and the weakness of her nature. Conolly (1858), prescribed "happy hours .. making puddings .. in [the asylums] busy and cheerful and scrupulously clean kitchen".

Within twenty years of the Lunatics Act, however, the optimism of the reformists was demoralised: the "homelike" system of asylums was overcrowded, underfunded and understaffed. The rapidly growing numbers of the insane meant that the invisible restraint of moral management was pragmatically replaced with disciplinary techniques akin to those of the workhouse and the prison.

By 1898 the Society for Promoting Legislation for the Control and Care of Habitual Drunkards and the British Medical Association succeeded in the establishment of Certified Inebriate Reformatories through the Inebriates Act. The Act allowed for the forcible commitment of individuals who had been convicted of drunkenness more than four times in one year to between one and four years in a reformatory: since the task of these new

institutions was to rehabilitate the inmates a period of long confinement was necessary.

Significantly, 81% (3741) of those committed to the Inebriate Reformatories were women (Hunt 1987). This cannot be explained by a higher incidence of drunkenness among women, rather,

".. the near dearth of places for the reception of men would suggest that the 'women only' policy was not so much an unforeseen consequence of the operation of the Act, as a conscious decision on the part of those responsible for administering the reformatories and perhaps on the part of the government itself" (McLaughlin 1984, quoted in Hunt 1987).

The Inspector of the Reformatories, in passing reference to this preponderance of women, noted in his 1909 report that

"The predomination in the number of women over the number of men committed to the Reformatories is obvious and explicable. Several reasons combine to produce the result, three amongst them being the most potent: 1. the deficiency in institutional accommodation for men, 2. the reluctance on the part of magistrates to commit men and, 3. the difference between the effect of alcoholic excess upon men and women... It has been necessary to point out .. that the most cogent of all reasons why more women than men find their way to Reformatories is the different effect of alcohol upon the two sexes. A drunken woman nearly always becomes hysterical, laughs or dances, or sits on the pavement and screams. She 'goes for' her drinking companion on the slightest provocation, and a policeman has an attraction for her which she cannot possibly resist. A drunken woman quietly wending her way homewards is a sight rarely to be seen...

Consequently drunken women get into trouble."
(quoted in Hunt 1987 p.5).

The Inspector accounts for the reluctance of magistrates to commit men because they were usually the "breadwinner" with dependent families. Women drunkards, however, had often "cut loose" from any family connections, and consequently were considered neither potential breadwinners nor 'real' women with family responsibilities. Drunken women belonged neither to the realms of the labour market, nor to the realms of domestic femininity - in their inabstinence they were truly monstrous, and ripe for confinement. Hence Barrington et al (1910) declared that in women

"... extreme forms of alcoholism are the result of a strong physical nature under little mental control" (quoted in Hunt 1987, p.8).

And they argued for an extension of the 1898 Act, since such monstrous women will, on release, resume their former unnatural inabstinence. Furthermore, they contended that such women were in danger of passing their derangement onto their children, who would then become a public liability.

The movement away from drink as a demon in itself, to alcohol as the agent, the *germ*, which draws out

inherent pathology was fully expressed in

Branthwaite (1908):

"Alcohol, far from being the chief cause of habitual inebriety is merely a medium which brings into prominence certain defects which might otherwise have remained hidden" (quoted in Hunt p.8).

The "hidden defects", Branthwaite goes onto discuss, involve primarily the failure to submit to the routine of regular work, dishonesty, filthiness and the lack of chastity in women. These pathological individuals do not adhere to the ethical codes of society, and consequently can justify anything that suits them. Furthermore, he asserts that drunkenness among women has "materially increased":

".. while temperance workers have succeeded in inducing the moderately strong minded healthy man to exercise restraint .. they have been unable to do much towards obtaining the same result in regard to the very persons who need it most .. (Branthwaite in Hunt).

.. namely women. Branthwaite asserts that women are therefore "more deserving" of long term institutional care - or imprisonment - so as to enforce abstinence from both drinking and sex (since the "persistence" such pathology evidences its heredity).

At the turn of the century concern about the falling birth rate and the proportion of recruits rejected as physically unfit during the Boer War began to focus therefore on the significance of maternal drunkenness. Between 1899 and 1904 the use of pubs by working class women was extensively scrutinised (Gutzke 1984): the suspicion was that maternal drinking was causing infant deaths. In 1902 the Royal Commission on Alien Immigration provided positive evidence that breast-fed babies and adult sobriety accounted for proportionately more children of immigrants surviving infancy. And by 1903 "burgeoning" maternal drinking was explicitly connected with deficiencies in National Efficiency and fears of British racial decay (Gutze 1984).

By 1904 scientific tests clearly showed that

"... miscarriages and malformed foetal cells often resulted because foetuses could receive alcohol from their mother's circulatory system. Furthermore, alcohol, by being present in breast milk or destroying it's nutritive value, had caused significant numbers of infant deaths, and was therefore one component of physical deterioration" (Gutzke 1984, p.74).

And

"The child deprived of an immunity which should be transmitted from its parents (ie the child which has it's tissues deprived of their power of resistance as the result of

the action of alcohol on the mother) runs a much greater risk of contracting early and fatal diseases than other infants" (Woodhead 1906, quoted in Gutzke 1984).

The Royal Commission was supported by a journalistic campaign led by George Sims who asserted that not only were mothers guilty in actually consuming alcohol, but also in taking their children with them into pubs (Sims 1907, in Gutzke 1984). He argued that along with the likelihood of consuming poisonous alcohol, these young children often contracted fatal respiratory diseases or became emaciated - deprived of breast-milk by their irresponsible drinking mothers. And by 1908 The Children and Young Persons Act prohibited children under the age of 14 from entering a public bar, which effectively legislatively curtailed women's access to the pub. Thus inabstinent women were firmly established as a national menace⁷ by the end of the first decade of the twentieth century.

Drinking and drunkenness, particularly among women, increasingly became the target of temperance reformers concerned with the moral and racial degeneration of the nation. And alongside the growing concerns over national efficiency

towards the end of the nineteenth century and the beginning of the twentieth century, the Brewing Industry was facing a parallel crisis. The 1830 Beerhouse Act had led to the production of a new beer ('porter') which was easily made in large quantities, using bigger brewery equipment but with no increase in labour power. This meant that beer was now a cheap and readily available (within market controls) means of working class leisure. And up until the 1880s the developing economy and the strength of the Trades Unions saw a steady rise in wages, facilitating working mens leisured consumption of beer in pubs, and thus the production of surplus value in the alcohol industry.

From the 1880s, however, although wages continued to rise, the consumption of beer fell (Dorn 1983). This was largely due to the increasing range and availability of cheap, mass produced consumer goods and generally widening social and recreational opportunities, which widened the possibilities of leisured consumption. The pub, therefore, faced competition from music halls, football matches and even railway excursions. And

consequently, although the conditions for the production of surplus value through the alcohol industry were still favourable, the conditions for their realisation, though market sale worsened. Brewers now faced the problem of having increasingly large productive units competing with each other within a market that was no longer expanding. The discovery of new markets through export was not a possibility since beer was too bulky and too expensive to export profitably. Brewers therefore were unable to realise in the market all the surplus value that they could produce. And from 1900 wages fell and the situation for brewers got worse.

Furthermore, the 1859 Beerhouse Act had compelled brewers to buy retail outlets in order to safeguard their trade from competing brewers, effectively reducing the number of independent publican retailers as the price of pubs rose in the competition between large brewers. And as the nineteenth century drew to a close the increasingly uncertain returns of the alcohol industry saw the brewers make increasing use of the Public Liability Acts of the 1850s which

enabled them to sell shares in their businesses and thus to raise capital from private sources. However, between 1889 and 1905 the falling profitability of pubs meant that share prices fell by 92% (Dorn 1983). And economic conditions remained unfavourable to the alcohol industry for the next 50 years.

The only solution to the brewers problems of over production was either to expand demand or else to destroy excess capacity. In the face of the impossibility of increasing demand, the brewers accepted that "an orderly reduction of retail outlets was in the interests of the industry". The 1904 amendment to the Licensing Acts of 1828 - 1902 levied all brewers and licensees in order to establish a fund to compensate those brewers and licensees who went out of business in the unfavourable economic climate. The licences of failed premises were made extinct and business was transferred to remaining pubs.

In this economic climate the brewing industry was able to take advantage of temperance reformers pressure to reduce the availability of alcohol.

Although temperance reformers were not wholly satisfied with the reduction in the number of pubs and called for firmer legislation which would abolish the 1904 amendment and thus abolish compensation for brewers and licensees going out of business, and although the prohibitionist wing of the British temperance movement called for all alcohol production to cease, the House of Lords blocked legislation to these effects in 1906. In 1911 the Lords veto was removed; however, the government introduced no legislation concerning the production of alcohol or a more vigorous curtailment of its distribution despite temperance pressure. The 1914 Defense of the Realm Act raised tax on alcohol over certain strengths as a means of raising revenue for the war and also of reducing drinking among workers in the war industries; and later in 1914, the Defense of the Realm (Consolidation) Act brought breweries and pubs in areas of the manufacture of munitions, war transport and armed forces encampment under public ownership. The consequences of this were that some breweries and pubs closed, but that the remaining were improved to include restaurant facilities and games rooms. Although the expenditure on alcohol

per head in these areas (Carlisle being the largest) was reduced and there was a general decrease in insobriety and arrests for drunkenness, temperance reformers were concerned that the State had become a purveyor of alcohol rather than introducing national restrictions or even prohibiting the sale of alcohol.

The launch of the Strength of Britain Movement in 1916 enabled temperance reformers to assert that State control over the distribution of alcohol was not enough to stem the flow of intemperance:

"We are concerned that the dangers confronting us arise from the sudden possession of abundant wages rather than from a lack of patriotic feeling: untrained in spending or in thrift, large numbers of our workers waste their resources on drink. The greatest good a government can render to its people is to strengthen their right purpose and weaken their temptations, and there lies upon us now the double duty of protecting our people from the temptation to drink away their earnings and of protecting the State from the intolerable folly of having high wages turned to the advantage of our enemies." (Alliance News, Feb 1920 p.25).

Although the Strength of Britain Movement had wide support it failed in its aim to get the government to suspend all sale of alcohol during the war. Despite this, its influence on health education was pervasive and long lasting.

"In a war situation in which the demand for labour was high, wages better than previously and the working class increasingly confident, health education offered a channel for inculcation of habits of discipline and self-restraint... The significance .. of health education is the way it stands as a clearly crystalised form of 'knowledge' derived from the states concerns.." (Dorn 1983, p40).

In particular, the lasting effect of the temperance reformers on health education, 'crystalised' social concerns over women's inabstinence as a national menace - destroying children and marriages and leading to a breakdown of social order.

From the seventeenth to the twentieth century, therefore, drunkenness became increasingly subject to social control. The social/political form of drunkenness as a refusal to engage in rational employment was domesticated as alcohol was commodified, available only in market terms. Drunkenness thus became illegal insofar as it was beyond the bounds of the rational transactions of market - and drunks were banned from pubs as 'bad for business'. Production as rational human activity was distinguished from consumption as the means of leisured refreshment. Such leisure was justifiable only through capital abstinence -

enforced through the development of taxation and of the marital abstinence of women from waged labour. Taxation provided the means for reform in the irrational sphere of the distribution and consumption of social goods, for example in the form of policing; and the marital abstinence of women ensured that men retained the opportunity for rational productive expression and thus also of leisured consumption - men retained the means of self expression through their consumption of women. The development of the state and of state intervention in the sphere of consumption facilitated the patriarchal /paternalistic control of women refusing to be abstinent and the violent enforcement of women's abstinence through rape and sexual violence was replaced by the rehabilitation and domestication women in their consumptive status. Hygiene became the effective means of the control of women and by the early twentieth century inabstinent women were seen as both the cause and the consequence of social ills leading to national and racial decline. The role of the state was now to control the distribution and thus consumption of alcohol, rather than the distribution and consumption of women, who had

been hygienically domesticated. Health education became the means of social welfare, with only the most incorrigible women remaining inabstinent.

CHAPTER 2:

THE RULE OF THE FATHER

The uneasy alliance of the temperance educators and the alcohol industry went some way to consolidating the articulation of production and consumption with regard to the social form of drinking: the majority of individuals, being rational, responded to the discipline of the market regulation of alcohol, and to rational education on the dangers of alcohol. Those individuals, however, who persisted in drinking beyond market controls (outside the pub and the market), and contrary to rational education became a matter for Expert concern.

The Victorian rational reformist deduced the source of such irrationality in "the three Ws - worry, want and wickedness", and sought the cure in the "three Ms - method, meat and morality" (Granville 1877 in Showalter 1987). However, the domestic provision of the 'three Ws' was under increasing strain as the numbers of the insane expanded; and, in view of the quantitative nature of the problem, the new Positive Experts asserted

their authority as independent of any questions of morality, as a matter of fact:

"For us science requires spending a long time in examining the facts one by one, evaluating them, reducing them to a common denominator, extracting the central idea from them. For them [the rational reformists] a syllogism or an anecdote suffices to demolish a myriad of facts gathered through years of observation and analysis; for us the reverse is true" (Ferri 1886 quoted in Taylor, Walton and Young 1973).

These new Experts, in arguing that science (as a matter of fact) is independent of, and the arbiter for all sectarian interests, required autonomy, particularly autonomy from the political influences of the State and the public pressure. The autonomy and scientific integrity of the Expert was such that he¹ was not interested in competing for share in the distribution of social goods, rather, he was concerned to resolve problems that could not be dealt with in either the production or the distribution of social goods. The Experts concern was to regulate the frontiers between public production and private consumption, to patrol the particular individual form, or expression of the articulation of these two spheres, since disorder in the individual form was conceived as positively indicating disorder in the social form (Chapter 5).

The Positive Experts, therefore, were concerned to scientifically identify accurate and calculable units of deviation from the norm. The first sets of criminal statistics (produced in France from 1827 onwards) provided the means of developing this 'moral yardstick'. Quetelet (a Belgian mathematician) and Guerry (a French lawyer), although working independently, both noticed that these first scientific descriptions of crime showed that, firstly, the annual totals of recorded crime remained extraordinarily constant; and second that the proportional contribution of various types of crime to the annual total barely fluctuated. On the basis of this empirical fact, these 'moral statisticians' concluded that crime was a regular feature of social activity, and therefore could not be regarded as a product of irrational individual (and therefore arbitrary) propensity to antisocial deviance. Furthermore, as crime must now be regarded as regular, predictable, and rational, it would (theoretically at least) be possible to eliminate crime and deviance. Rigorous scientific investigation, in "examining the facts one by one and evaluating

them" enabled 'moral scientists' to reduce social fact to a common denominator (or universal equivalent). That common denominator was logically induced as the 'cause', and defined the means of 'cure'. In the case of moral, or social science, the common denominator was the individual.

By the 1870s, the ideas of the moral statisticians were complemented by Darwin's (1871) biological discoveries. The statisticians observed that different groups of individuals engaged in different forms of activity, some more 'social'/civilised/utilitarian/valuable than others; Darwin (1871) discovered that some life forms were more primitive than others, and postulated a drift towards ever greater biological variation and differentiation between the species. Since humanity was continuous with other species, he inferred that some individuals were more evolved than others (and that rich men may be in the evolutionary vanguard since they were obviously so well adapted to the civilised (capitalist) environment).

In 1876, Lombroso published his observations on human biology. He described his experience on examining the skull of a famous brigand:

".. a flash of inspiration. At the sight of the skull, I seemed to see all of a sudden, lighted up as a vast plain under a flaming sky, the problem of the nature of the criminal - an atavistic being who reproduces in his person the ferocious instincts of primitive humanity and the inferior animals. Thus were explained anatomically the enormous jaws, high cheek bones, prominent superciliary arches, solitary lines in the palms, extreme size of the orbits, handle-shaped or sensile ears found in criminals, savages and apes, insensibility to pain, extreme acute sight, tattooing, excessive idleness, love of orgies, and the irresistible craving for evil in its own sake, the desire not only to extinguish life in the victim, but to mutilate the corpse, tear its flesh and drink its blood" (Lombroso, 1911, quoted in Taylor, Walton and Young 1973, p.41).

"Atavistic" man was to be recognized in series of physical stigmata, which distinguished him absolutely from normal men. This clear qualitative difference provided the definition of criminality as something essential, in the nature of atavistic creatures, rather than as a malfunctioning of the social organism. And these asocial creatures were conceived as literally beyond society, quite incapable of posing any threat to the social organism. Atavistic men were thus ideologically^a confined to an asocial space quite as remote from

the business of rational society as the
Enlightened Houses of Confinement.

Furthermore, in postulating a drift towards ever greater biological variation and differentiation between the species, Darwin (1871) regarded the increasing sexual differentiation of social roles characteristic of industrial capitalism as a mark of evolutionary advance. Women, in their essential lack of productive activity³ were conceived as a different and less evolved species of humanity than men. Consequently, women, despite their persistently lower crime rate, were *all* conceived as "relatively primitive", and thus, "atavistic". Hence, tautologically, women's essential abstinence from rational productive activity.

Deviant women, however, who denied their natural feminine abstinence⁴ from such public activities, became a particular problem for the Positive Experts: women's general atavism meant that the criminals/deviants among women would be relatively less visible and less degenerate than their normal sisters. As the moral yardstick used by the

growing body of positive Experts to identify deviant women was defined in terms of the statistically normal atavistic woman, women who acted in a non-feminine, masculine manner (such as drinking alcohol) were considered to be more evolved than their abstinent sisters, but still less evolved than normal men, who were rationally incontinent. Thus deviant women were conceived as unnatural - rejecting the demands of their evolved biology, but physiologically incapable of equality with men. Lombroso and Ferrero (1895) asserted that

".. the born female criminal was perceived to have all the criminal qualities of the male plus all the worst characteristics of women, namely cunning, spite and deceitfulness" (Lombroso & Ferrero 1895 p.33).

The progress of positive social science by the end of the nineteenth century provided the means of identifying social disorder - not in capitalist productive relations and the unequal distribution of value - but in women's unnatural demands for economic freedom and independence: women's refusal to abstain^o:

"The attempt to alter the present relations of the sexes is not a rebellion against some arbitrary law instituted by a despot or a majority - not an attempt to break the yoke of mere convention; it is a struggle against nature; a war undertaken to reverse the very

conditions under which not man alone, but all mammalian species have reached their present development" (Geddes & Thompson 1890, p.122)

Darwin's scientific authority allowed for the reassertion of the hierarchy of natural law, and women's increasing demands for equality and freedom were met by medical warnings of sickness.

As society was organically conceived as a body of functionally related parts all comprising (qualitatively different) individuals, so too was the individual conceived as a "series of separate, interdependent systems", the common denominator being in this case the cell. And, as in the case of the social organism, the individual constituents of the human organism were conceived as qualitatively different: Geddes & Thompson (1890) identified two opposite types of process at the level of the cell: "anabolic" processes, described as "upbuilding, constructive, synthetic processes", and "katabolic" processes, involving "disruptive, descending chemical changes". And, as the organisation and activity of matter in the social organism is analogous with the organisation and activity of matter in the human organism

"... the processes of income and expenditure must balance, but only to the usual extent, that expenditure must not altogether outrun

income, else the cell's capital living matter will be lost - a fate which is often not successfully avoided... Just as our expenditure and income should balance at the year's end, but may vastly outstrip each other at particular times, so it is with the cell of the body. Income too may continuously preponderate, and we increase in wealth, or similarly, in weight, or in anabolism. Conversely, expenditure may predominate, but business may be prosecuted at a loss; and similarly, we may live on for a while with loss of weight, or in katabolism. This losing game of life is what we call a katabolic habit" (Geddes & Thompson 1890 quoted in Martin 1987, p.33).

Geddes & Thompson applied the logic of rational business to the body, to conceive that the female of the human species comprises predominantly anabolic cells, while the male comprises mainly katabolic cells. And so, tautologically, he provided the biological explanation for the gendered nature of the public and domestic spheres of the social organism:

"It is generally true that the males are more active, energetic, eager, passionate, and variable; the females are more passive, conservative, sluggish and stable... The more active males, with a consequently wider range of experience, may have bigger brains and more intelligence; but females, especially as mothers, have indubitable a larger and more habitual share of altruistic emotions. The males being usually stronger, have greater independence and courage; the females excel in constancy of affection and sympathy" (Geddes & Thompson 1890 in Martin 1987, p.33).

Furthermore, positive science identified for the first time physiological functions that were seen

as uniquely female, without analogue in males. Pre-Enlightened conceptions of gender difference not only saw male and female secretions (male sweat and female menstruation) as analogous, but as desirable (Martin 1987). By the nineteenth century, however, female menstrual secretions were regarded as positively pathological:

"[Menstruation] evidently lies on the borders of pathological change, as is evidenced not only by the pain which so frequently accompanies it, and the local and constitutional disorders which so frequently arise in this connection, but by the general systemic disturbance and local histological change of which the discharge is merely the outward expression and result" (Geddes & Thompson 1890 in Martin 1987, p.34).

Women's essential and positive anabolism was contradicted by her faulty physiology in its monthly expenditure. Her positive anabolism was every month contradicted by her body; woman could not be free in so far as she was in thrall to her body. Thus women were conceived as intrinsically biologically pathological: they had two choices - either to obey their naturally abstinent biology, in which case the pathology was arrested, as they would become legally pregnant and bear healthy and legitimate children; or else, failing to be abstinent, become ill, bifurcated by the

contradiction of their bodies. Thus the physical economy of sex (Ehrenreich and English 1973).

So the attention of the social reformers began to turn away from the position of women on the labour market to the individual biochemical content of women's unequal position - their anabolism. The significance of the Factory Acts diminished in proportion to the ascent of the medics, who had proved that inabstinent women who neglected their natural biochemistry unleashed the latent pathology of their own bodies and the toxic process of alcohol on their body. The Experts found positive proof that women should abstain from (and be protected from) the unnatural ardours (for them) of the labour market, since it would cause physical and mental breakdown. Furthermore, since mental disorder, once contracted, could be transmitted to the next generation (chapter 1), women should not only be protected from themselves, but society should be protected from the dangers of their unnatural unabstinent activities.

Thus doctors became Experts in dealing with problems of social disorder: problems or disease of the social organism was positively reduced to the disease of its individual parts. The positive explanation of disease in terms of the functional differentiation of the social and human organism allowed for the conception of individual diseases (such as drunkenness) as

".. discrete, distinctive entities, differentiated from one another in terms of their causes, symptoms, patterns, course and outcome" (Busfield, 1986, p.36).

The earlier notion of disease as something over which human rationality was powerless, was replaced by the idea that the individual character was expressed through health or illness: if the individual neglected her naturally abstinent instinct, she would become ill. Thus disease became a product of human (rather than supernatural) will; and health was conceived as the assertion of a 'healthy will' over the 'rebellious forces' of the 'sick will'. The health of society thus required the healthy assertion of the individual human will (chapter 5):

"Disease is the will speaking through the body, a language for dramatising the mental: a form of self-expression." (Sontag 1978, p44).

Freud articulated the increasingly prevalent view that individuals were subject to invisible forces beyond the intervention of their conscious healthy will. In his Three Essays on the Theory of Sexuality (1905) Freud announced his discovery of infantile sexuality. This facilitated Freud's development of the concept of the unconscious through the thesis of "infantile amnesia" - the idea that something blocked each individual's memory of their own childhood experiences. It also immediately extended the concept of sexuality beyond the physical matters of reproduction to a central position in the structuring of all social behaviour.

From his discovery of the unconscious, Freud hypothesized that the child is born with two sets of instincts - the sexual and the self-preservative instincts. Initially these are "at one with each other": suckling at the mothers breast provides the means of staying alive as well as of sexual gratification. However, as the child develops, the sexual and the self-preservative instincts become opposed, and it is in the growing antagonism of the two that the psyche is

structured. As the sexual instinct seeks pleasurable gratification, the self-preservative instinct (the ego) discovers that pleasurable gratification is not always possible. And as the failure to satisfy a sexual urge causes unpleasant irritation, the instinct for self-preservation renounces immediate gratification for satisfaction in the long term. Thus, reality ensured the separation of the psyche into two major areas - the conscious and the unconscious - each maintained by different instincts (that of self-preservation and the sexual instinct), affected by different principles (reality and pleasure), and governed by different agencies (the ego and the id).

This individual psychodynamic development can be seen as entirely analogous with liberal notions concerning social development: *originally society was "at one"; as civilisation evolved, however, the spheres of production and consumption separated as the reality of inequality, of the dissatisfaction of sections of society, required the abstinence (deferred gratification) of some sectors of society in order to ensure social order*

and well-being in the long term. The particular form of society, the specific relation and articulation of social production and consumption, is defined in the specific social relations of 'deferred gratification' (ie who defers her pleasure to whom) and the specific form that abstinence takes.

According to Freud, it is in the separation of the psyche into the spheres of the conscious and the unconscious that the individual is constructed. And further, the boundary between these two realms is defined in the child's changing relationship to her own body, in particular her sexual impulses. This relationship changes as desire - the sexual instinct - is limited by reality. And so Freud conceives of the individual as socially constructed, albeit on a biological basis (Wilson 1987). And Freud defines the specific social relations of deferred gratification, of the articulation of the conscious and the unconscious (and production and consumption) in sexuality.

Freud forwarded that the individual (sexuality) evolves through a number of stages before it

reaches it's normal adult heterosexual form. The first stage is the stage of oral sexuality, which 'naturally' arises in the pleasure that the infant receives from suckling her mother's breast, and can be transmitted to substitutes such as the infant's own thumb. Secondly, the child develops anal sexuality through the enjoyment of controlling the expulsion of faeces. During these two stages, the child can obtain sexual pleasure without the intrusion of an external ("real") object. It is this domination by the sexual impulse, the pleasure principle that characterises infantile sexuality. This is a state of pre-consciousness, a state untouched by reality: a pre-social state.

Reality, however, makes itself felt upon this pre-conscious state of masturbatory auto-eroticism as genital sensations begin to emerge, and begin to surpass oral and anal sensations as the infants greatest source of pleasure. However, in the satisfaction of these genital needs, the child is dependent upon others: in particular, her mother. The initial symbiotic relationship that the infant experiences at her mothers breast is transformed

as the child comes to realise that she does not entirely possess her mother in the satisfaction of her sensual needs: she shares her mother with an other - her father - who possesses a more explicitly sexual relationship with her. It is in these ever-increasing demands that external reality makes upon the infant, and in particular the resolution of castration and oedipus complexes that the Ego is formed, and an 'adult', heterosexual and genitally focused sexual outlook emerges out of the pre-conscious, masturbatory sexuality.

Briefly, the oedipus complex describes the child's desire to kill her father and have sexual intercourse with her mother. The child sees her father as a rival in her love for her mother. The boy child fears his father because he believes his father will castrate him as a rival. Freud sees this fear as originating in the boy's belief that his father will castrate him; this belief, in turn is founded on the boy seeing his mother or sister naked, and penis-less, presumably castrated. The boy has both a narcissistic and a realistic attachment to his penis, and so in order to

preserve it he renounces his sexual love of his mother and identifies with his father instead.

"The authority of the father .. is introjected into the ego, and there it forms the nucleus of the super-ego which takes over the severity of the father and perpetrated the prohibition against incest" (Freud, 1977, p 319).

The fear of castration and the identification with the father therefore provide the resolution to the oedipus complex, and the formation of the ego.

In the case of the girl child, however, she must change both the organ (clitoris to vagina) and the object (mother to father/men) of her love in order to achieve sexual maturity. Freud conceives the early desire of the girl for her mother as 'masculine', based on the clitoris: "the little girl is a little man". However, in seeing her father or brother naked the little girl realises that she is different and castrated. The little boys fear of castration "smashes" his oedipus complex, facilitating his renunciation of maternal love and his identification with paternal authority. However, the little girl does not fear castration because she is already castrated, and consequently the oedipus complex is not resolved, it is initiated. The girl is struck by the

superiority of the penis over the clitoris; in recognizing the inferiority of the clitoris, she turns away in anger from her mother, wishing to possess a penis herself. She blames her mother for her own deficiency and sees her as an unworthy love object in the absence of her penis also. She turns now to her father, hoping that he will make good her lack; and at the same time, she develops the passive sexuality of the vagina in favour of the phallic sexuality of the clitoris. The girl develops a desire for other men in substitute for her father, and her wish for a penis is replaced by it's symbolic equivalent: the wish for a baby.

Freud identified the repression of the oedipus complex as the basis of civilisation. He explained the institution of social order in terms of the oedipus complex: in Totem and Taboo (1913) Freud forwarded that the first human society was established as one male enforced rule over all other individuals. This ruling man, the 'father' subjugated all other men, his 'sons', and monopolised all women. Here the oedipus complex was collectively enacted: as the 'sons' became increasingly jealous of and angry with their

'father' they banded together to overthrow the father. In the coup, they killed the father and devoured his body. Freud contends that it was this original act of killing the father that "was the beginning of so many things - of social organisation, of moral restrictions and of religion".

Thus this original realisation of the oedipal situation was the basis for all social activity; prior to this first social activity, all individuals were alone, aggressively acting against each other. And this original act of defiance of the father was so important that it is rehearsed in each generation since, with the fear of every child of castration symbolising the murder of the ancestral father and the resolution of this fear being the prerequisite for the entrance of each individual (male and female) to adult social life.

Freud, therefore, transformed the Social Contract into the murder of the father. And in doing so, he claimed this first social act as proof of the forces of man's unconscious mind: he flooded doubt

into the notion that the birth of reason was the impetus to society - the mystery of the unconscious replaced rationality as the motive for society. And sexuality was established as the crucial substance maintaining the structure of society. And, for Freud, the specific dynamic of sexuality defined the stage of evolution of a society.

The relationship between sexuality and civilisation was explicated by Freud in his concept of libido. The concept of the libido described the dynamic relationship between the instincts of self-preservation and sex; and Freud contended that these instincts, principles (reality and pleasure) and agencies (ego and id) were ultimately reducible to the "economics of the libido". This idea was premised on a conception of each human being as

".. a closed system with a static quantity of energy which could be redirected but not increased or diminished. Similarly .. the libido was a form of energy that could not be contained; it's force had to express itself in some way, whether it was sexual pleasure, neuroses, or in its other sublimated and repressed forms" (Foreman 1977 p.46).

In Freud's words:

"The quantitative factor is no less decisive as regards capacity to resist neurotic illness. It is a matter of what quota of unemployed libido a person is able to hold in suspension and of how large a fraction of his libido he is able to divert from sexual to sublimated aims. The ultimate aim of mental activity, which may be described quantitatively as an endeavour to obtain pleasure and avoid unpleasure, emerges, looked at from the economic point of view, as the task of mastering the amounts of excitation (mass of stimuli) operating in the mental apparatus and of keeping down their accumulation which creates unpleasure." (Freud 1917)

Furthermore, Freud forwarded that the repression and sublimation of the libido was responsible for the development of civilisation, including the individuals basic capacity for thought. Freud traced the relationship of the repression of the libido with the growth of civilisation through his concept of the superego. The concept of the superego is crucial in completing his theory of the unconscious: it is his category of physical agency, after the ego and the id, and is defined as the inheritance within the psyche of the individuals childhood sexual urges. The superego is defined in the continual force of the individual conscience as it contains the repression that occurred through the resolution of the oedipus complex; and therefore its strength is in proportion to the force of the repressed

libido. Extrapolating from the individual to society (that being the sum of its parts), Freud considered that the strength of each individuals superego (or 'will') was an index of the development of civilisation.

The problem for Freud's conception of civilisation, however, was that anthropological studies do not bear out his claim to universal truth (Foreman 1977). However, Freud's analysis of the individual separation of the ego from the id - of the instinct of self-preservation from the sexual instinct - provides the means of translating contemporary social anxieties concerning inabstinence to the individual psyche. Freud describes the feeling of threat that the conscious mind feels in its relationship to the unconscious mind. The threat is experienced in the inability of the conscious individual to rationally explain the (unconscious) area of feelings and emotions. *Extrapolating from Freud's description of individual psychic experience to the social experience of the relationship between production and consumption, an analogous 'threat' or anxiety can be seen in the increasing social*

attention to the specific social relations of deferred gratification (who defers their pleasure to whom) and in the specific social form of abstinence. In short, the social concern about sexuality and in/abstinence (Chapters 1 & 5). Freud provided the means of translating this social anxiety into the individual and her specific libido economics.

Although Freud's conception of society was based on the principle of the pursuit of pleasure, it was not the optimistic vision entertained by Mill and Bentham - who believed that in a rational, if bifurcated, society the happiness of the individual would accord with that of the majority. Freud's pleasure principle was not a rational principle. For Freud, rationality (in the form of the reality principle informing consciousness - the ego) acted in opposition to the pleasure principle, which was accordingly repressed within the unconscious. Thus the pursuit of pleasure does not result in happiness: the libido may be unsuccessfully redirected and emerge in the form of anti-social neuroses, or through the death instinct in the form of aggression and sadism.

"Freud's darker vision of the pleasure principle portrayed a society where communal happiness was bought in the beginning with an act of murder and maintained at the expense of individual neuroses" (Foreman 1977, p.67).

Mill distinguished the realm of the market from that of the family, identifying the family as beyond the influence of the reality and rationality of the market; Freud distinguished the realm of the conscious from that of the unconscious, and identified the realm of the unconscious as beyond the rationality of the ego and the control of reality. In liberal economics, the means of articulation of the market and the family is the abstinence of women - from employment, sexual gratification and drunkenness. In the economics of the economics of the libido, the means of articulation of the ego and the id is the superego: the conscience derived from the successful resolution of the oedipus complex by the repression of the sexual instinct into the unconscious.

Women, however, have no need to repress their desire to love the mother and kill the father (since this disappears as penis envy is realised) have a less developed superego, or conscience than men. Likewise women have less libido than men.

Thus Freud develops a psychoanalytic account of the relative exclusion of women from the social contract: women possess a lesser sense of justice, and are more naturally abstinent than men^a. They are both qualitatively and quantitatively different from men. And as Mill identified the means of articulation between the social spheres of production and distribution in a sexualised conception of abstinence, Freud conceived the articulation of the bifurcated individual (into the conscious and the unconscious) through sexuality. A healthy dynamic between the repression/abstinence and expression of sexuality, therefore, was necessary to ensure the order and well-being of both the social and the human organism.

Freud's concept of human nature lies in his assertion that the Oedipus complex explains cultural norms, rather than vice versa; and further, in his explanation of the traumatic sight of 'castrated' genitals (Foreman 1977). As such, Freud described his perception of contemporary cultural norms, and in particular, gender roles as based/determined by biology - by the sight of our

own genitals in relation to the sight of others genitals, and the experience our individual body, in particular our genitals, in relation to that perception. Social reality effects the Freudian psyche only insofar as the infantile splitting of the conscious from the unconscious is catalysed by the early sight of genital difference - social reality is thus mediated through the body in the development of psychic reality. Thus the definition of the boundary the unconscious and the conscious is, for Freud, through the individuals relationship to her body.

The resolution of the girls castration complex and her development to healthy heterosexual maturity, then required her to shift the focus of her love from her mother to her father at the same time as shifting the locus of her sexuality from her clitoris to her vagina. This dual shift was not only problematic in analysis:

"It must be admitted ... that in general our insight into these developmental processes in girls is unsatisfactory, incomplete and vague." (Freud 1977, p.321)

But also problematic in women's achievement of a mature heterosexual sex-role identity. In the face of such difficulty, *psychoanalysts tend to deduce*

that normally developed women defer the gratification of their sexual impulse (and of their pleasure in general) to men and babies, abstaining from the active (phallic) pursuit of pleasure. This mirrors the socially functional definition of femininity as providing emotional support and affection to a man, who is the active and instrumental leader of the family (Parsons & Bales 1956). Femininity is thus characterised as dependency and submissiveness - in short abstinence from activity and pleasure.

Despite the problems of analysis that Freud encountered in theorising women's sex-role development in terms of his theory of the psychic origins of society, in assuming the objective authority of a scientific Expert, however, Freud's conception affected the status of fact.

Freud further established the role of the psychiatric expert in the explanation and resolution of social problems in elaborating the notion of the unconscious as something only observable to the Expert eye. The existence of the unconscious was only perceptible through

'parapraxes' (slips of the tongue), dreams and the revelations of patients under hypnosis. Thus not only were individuals afflicted with diseases determined by forces beyond their conscious will (and therefore not free), but also dependent upon expert psychiatric treatment in curing the ill. The dependent status of the patient concurred with the positive consolidation of the abstinent and dependent essence of women (Ehrenreich and English 1973); and also with the conception of women as relatively more unconscious than men. So, by the 1930s, the market discipline of price, the educational discipline of morality and repressive discipline through policing was supported in the institution of women's abstinence with the establishment of the psychiatric profession.

Freud observed that intoxication distances the individual from other individuals by changing the mode of consciousness - mimicking whilst simultaneously depressing the unconscious, and therefore falsely repressing the sexual instinct. The id was repressed not through a healthy resolution of the oedipus complex, but artificially, through drugs; and the appearance of

satisfaction of the pleasure principle mimicked the expression of the libido (Foreman 1977). Freud observed the withdrawal into intoxication so frequently in response to "alienating circumstances" that he noted that "... individuals and peoples alike have given [psychotropic drugs, such as alcohol] an established place in the economics of their libido". Despite the ubiquity of intoxication, however, Freud contended that drunken individuals were pathological: the repression of the id through psychotropic drugs indicated a pathological development of the psyche, in particular, the blocked development of the superego. Drunken individuals, therefore, had a deficit of conscience; and, insofar as they remained inabstinent, were uncivilised, incapable of participating rationally in contemporary society. In order to earn their place in civilisation, such pathological individuals required psychoanalytic therapy, in order to enable them to resolve psychic conflicts and develop to maturity. Thus the location of the problem of inabstinence in the early childhood of the individual; and thus the power of the psychiatrist over the pathological individual: the

conflicts were not only invisible to the untrained eye, but located in the past.

Inabstinent women's failure to repress the id expressed not only their natural deficit of conscience, but also their failure to develop a normal, passive, other-directed female sex-role identity as they were futilely mimicking⁷ the male resolution of the oedipus complex. Inabstinence provided the appearance of the satisfaction of the pleasure principle, and thus of the expression of the male libido, but as it was artificially induced through drugs and naturally impossible for women to obtain, these women were particularly pathological and in particular need of expert psychiatric intervention.

The failure to achieve a successful resolution to the oedipus/castration complex is traditionally explained in terms of either maternal deprivation or maternal over-protection. In brief, the general contention is that the pre-alcoholic infant was in some way frustrated during her first year. This frustration may have arisen either through the infant not receiving enough gratification, or the

infant receiving too much gratification.

Gratification includes feeding, holding, changing and crying. Too much gratification will not enable the infant to develop an adult tolerance for frustration; too much frustration will engender acute anxiety, excessive need for love, powerful feelings for revenge and the concomitant feelings of guilt and depression (Lisansky 1960, Jones 1971, Kinsey 1966, Boothroyd 1980). Either way a character structure develops which may manifest itself in adulthood in the form of a syndrome with oral characteristics: a focus on "taking in": alcohol, food, cigarettes etc.. Balanced, healthy maternal gratification requires the rational and discretionary exercise of abstinence: even although the mother is not the alcoholic, such theories identify the cause of alcoholism with the inabstinent mother.

Karl Menninger (1938) provided probably the most widely known psychoanalytic theory of alcoholism. He asserted that alcoholism is a form of self-destruction. The explanation is that as a child, the alcoholic was led by her parents to expect more oral gratification than she in fact received.

Through a "severe" process of weaning, the infants oral desires were frustrated and she was overcome with rage and a desire to attack her parents.

However, as Menninger points out

"The alcoholic suffers at the same time .. from the wish to destroy his love objects and the fear that he will loose them" (Menninger 1938, p.149).

Therefore, in not daring to attack the real causes of his rage, the alcoholic turns to drinking as a form of oral gratification and as a symbolic way of seeking revenge against her parents.

Consequently, for Menninger, alcoholism is a form of self-destruction^a that serves to avert an even greater self-destruction: the destruction of her love objects. The alcoholic pattern is progressive in that frustration at the oral stage of development leads to rage against her parents, which is suppressed through guilt and replaced through feelings of worthlessness and inferiority, and which in turn lead to alcoholism.

The early gender-neutral notion of alcoholism as a form of chronic suicide, has been supplanted by more gendered accounts of drinking. McClelland et.al. (1972) asserted that the strongest motivational factor in the development of

alcoholism in men is the satisfaction of power needs. Here, drinking is conceived as an attempt to rid the self of profound feelings of inferiority and to escape the demands of society. As such, alcoholics are characterised by hyperactivity and aggressiveness, both of which are seen as defensive tactics against inadmissible feelings of inferiority. The cause of these feelings of inferiority is identified in "maternal pampering and overprotection", which ensure that upon adulthood, the nascent alcoholic is unable to face the demands of society and turn to alcohol to erase the feelings of inadequacy.

While McClelland's study only involved men, many of their arguments assumed that women and men drink for the same reasons. For example, in observing that in most cultures men drink more heavily than women, and that in most cultures men are expected to be more self-reliant, assertive and achievement-oriented than women, they argued that men are more likely to develop "excessive" concerns with their personal power. Logically, they argued, that since women tend not to be concerned with personal power, they are likely to

drink less than men. The implication being that those women who do drink, do so in order - like men - to develop more feelings of power, which, in itself may be seen as pathologically inabstinent.

More relevant to women, although based again on studies of men alcoholics, is the idea that drinking is a means of expressing dependency needs. This psychoanalytic theory has its root in Fenichel's (1945) contention that oral frustration (not aggression) is the primary motive to alcoholism. He asserted that alcoholism is the expression of "passive, dependent, narcissistic" urges: which the wish to use the mouth as the prime source of gratification characterises the alcoholics attitude to life. Thus drinking provides the means of gratification of passive oral dependency needs, but within a setting^a allowing the drinker to maintain a facade of adult independence and assertiveness. The conflict between the desire for maternal love and dependency is in conflict with aggressive urges:

"There is a *repressed* but still active craving for loving maternal care. There is also a very strong aggressive need, suppressed by circumstances to the extent that it comes to expression only in verbal form. Alcohol does a lot for these two needs.

It permits the young man to act as aggressively as he really feels without forcing him to assume full responsibility for his actions. It permits him to gratify his dependent cravings without forcing his sober consciousness to become aware of them. Alcohol thus allows him to satisfy strong needs without disturbing the neurotic protective organisation that ordinarily keeps them in check" (White 1948, p.417).

While psychoanalysts note that individual dependency needs are "virtually universal", two phenomena are often cited as causing pathological dependency needs: maternal deprivation (McCord & McCord 1962), and the modern western adult male role which is defined as the absence of dependency, thus requiring the repression of the healthy male expression of dependency (McCord & McCord 1960). The achievement of modern Western masculinity is seen as requiring a "uniquely severe" switch from childhood dependence to adult independence, and pre-alcoholic boys, in their experience of maternal deprivation as they 'grow up', have intensified dependency desires which, simultaneously creates uncertainty about the kind of behaviour that will satisfy these urges.

"Liquor provides a suitable outlet for the person plagued by such a dependency conflict. Drinking .. is typically a masculine act: it conforms with the male role. At the same time, under the influence of heavy doses of liquor, a person can feel 'cared for' and comforted; his troubles flee, his desire for dependency is satisfied. Heavy drinking

removes the conflict between dependency desires and the necessities of the male role" (McCord and McCord 1960, p.56)¹⁰.

The male alcoholic, therefore is likely to experience sex and/or gender role confusion.

Related to this, such men are likely to experience low self esteem. Drinking is one means of dealing with the oral desire, the psychic conflict and the low self-esteem:

"To heighten our self-esteem, to abolish tension and anxiety, to dispel the threat to danger, to search for pleasure, to banish the self-recrimination of guilt .. are indeed ancient desires... To heighten self-esteem, we must temporarily paralyse the super-ego .. that part of the mind that is soluble in alcohol" (Fox and Lyon, 1955 pp38-39).

And it was from the psychoanalysis of alcoholism in men as an expression of dependency needs and sex-role confusion that the psychoanalysis of women alcoholics developed. Most psychoanalytic studies of women alcoholics concludes that they are characterised by sex-role confusion (McCord & McCord 1960, Boothroyd 1980, Blane 1968, Curlee 1967, Wilsnack 1973a, 1973b, 1976, Kinsey 1966, 1968 Parker 1972, Jones 1968, 1971, Block & Hahn 1971, Bardwick 1971, Gomberg 1976, Sciada & Vannicelli 1978). The 'basic psychopathology' of alcoholic women in these analyses is generally attributed, as it is in men, to "a deep sense of personal

inadequacy and lack of preparation for adult roles" (Kinsey 1968). This "personal inadequacy", in turn is attributed to early family experience. Some studies suggest (Curlee 1967) that women drink to gratify "masculine strivings", since drinking is culturally defined as a masculine characteristic; the majority of studies, however, associate drinking in women with "hyperfemininity" (Jones 1971), "feminine neurosis" (Parker 1972) or "traditional feminine attitudes" (Wilsnack 1973a, 1973b, 1976).

Wilsnack (1973a) found, for example, that after 2 drinks, the adjectives that women used to describe their feelings were generally unrelated to either power or dependency. Rather, they included "warm, loving, considerate, expressive, open, pretty, affectionate, sexy and feminine". In observing that these feelings or qualities are traditionally considered characteristic of women rather than men, Wilsnack concluded that alcohol enhances feelings of "womanliness", and thus that woman alcoholics may over-emphasize or over-value the "female role". Further, she hypothesized that

"The numerous reports of alcoholics sex role confusion or sex-role conflict may refer to

the presence of 'masculine' tendencies on less conscious levels of sex-role identity. If so, the picture that emerges is one of a woman who consciously wishes to be feminine but whose unconscious 'masculinity' causes her to feel somehow inadequate or deficient as a woman" (Wilsnack 1976, p.41).

Wilsnack suggested three possible explanations for alcoholic women's unconscious masculinity: firstly the oft reported early family history of woman alcoholics. In having a "cold, domineering" mother and a warmer, more passive and perhaps alcoholic father would facilitate, in this psychoanalytic perspective, the development of unconscious masculine tendencies through the individuals identification with the father. Similarly, the just as frequently reported family history of an inadequate, pathological and/or absent father (often alcoholic) and a negative or ambivalent relationship with the mother was likely to facilitate "identification with the aggressor", and the resultant development of unconscious masculinity. Second, Wilsnack suggests that unconscious masculinity may reflect the failure to develop a strong feminine identity, which she thought was due to the lack of a positive feminine model. And finally Wilsnack thought that women alcoholic's unconscious masculinity

".. may reflect some non-specific factor(s) unrelated to sex-role identity (eg general deviance from social norms, including deviance from expected sex-role behaviours), which would also characterise other deviant groups of women (eg women criminals, other types of psychiatric patients etc)" (Wilsnack 1976 p.46)

In discussing "sex-role conflict", Wilsnack (1976) refers to two different kinds of conflict, firstly intrapsychic conflict such that, for example, conscious feminine characteristics conflict with unconscious masculine characteristics within the individual. Secondly, "sex-role conflict" may be between the individual's sex-role identity and the cultural demands for traditional feminine (or masculine in the case of men) behaviour.

However, she stresses that although some form of sex-role conflict may be present in many alcoholic women, it is not sufficient to produce alcoholism.

"It is necessary to look at the way this conflict interacts with other stresses experienced by the alcoholic woman and at the interaction of psychological factors, such as sex-role conflict, with biological and sociocultural predisposing factors" (Wilsnack 1976, p.53).

She argues that women's life events play a major role in predisposing them to alcoholism (Chapter 3). In particular, she suggests that "divorces, separations and other marital problems and reproductive difficulties" are particularly likely

to "arouse doubts in most women about their adequacy or worth as women" (Willsnack 1973a), thereby predisposing them to drink.

An important, but often implicit strand in these psychoanalytic perspectives on inabstinent women is the view that as women become 'liberated', they will acquire masculine characteristics and roles which will engender, as it has in men, the inhibition of expressions of dependency. This will cause psychic conflict, which may find its expression in alcoholism (Boothroyd 1980). Massot (1957) was probably the first to explicitly state the implicit thesis that

".. alcoholism represents the ransom which women pay for their emancipation" (Massot 1957, p. 144).

His basis for this statement was that as women in general are more dependent upon social approval for self esteem than men in general, the shifting role of woman, and her greater participation within the contemporary labour market engender intense feelings of inferiority and sex-role insecurity. This is expressed in pathological strivings for love and appreciation, indicating

women's essentially high level of dependency, and often manifest in alcoholism.

Since then several other writers have commented on the stressful effects of waged labour on women which may predispose them to alcoholism (Sclare 1970, Keil 1978, Shaw 1980):

"At one time, prevailing social attitudes maintained that it was normal for a woman to be a housewife, that it was natural for her to be passive, demure, and emotionally warm, and that her most fulfilling achievement was to give birth .. the role of the housewife and mother is now often referred to as dull, imprisoning and demeaning .. the feminist lobby have tended to lean .. towards male criteria of success and achievement through obtaining status, acclaim or high earnings. Roles adopted in a woman's working life can be discrepant with the traditional stereotype of women as non-competitive... Behaviours and roles that were once universally seen as natural and fulfilling are now implicated as the ideological values of a sexist society, whilst those same ideologies are still strong enough to undermine any new roles and behaviours for women" (p.26-27).

The problem, however, is that as women turn to alcohol in an attempt to resolve sex-role conflicts, these insecurities are exacerbated as drinking is culturally regarded as a masculine activity: as such a woman drinks even more to defend herself against deepening feelings of 'unfemininity' a vicious cycle is established

(Wilsnack 1976). A psychoanalytic model of a woman at risk of developing alcoholism is one who

"... experiences chronic doubts about her adequacy as a woman. These doubts may arise in part from sex-role conflict on less conscious levels of personality, and may be enhanced by acute threats to the woman's sense of feminine adequacy (marital problems, a miscarriage, children leaving home and so forth). The potential alcoholic does not consciously reject her femininity, nor does she explore alternative roles (eg trying to integrate her 'masculine' and 'feminine' personality characteristics); rather, she consciously values traditional female roles and tries to conform to traditional sex-role expectations. She may manage to cope with her fragile sense of feminine adequacy for a number of years, but when some new threat severely exacerbates her self-doubts, she turns to alcohol, perhaps in an attempt to gain artificial feelings of womanliness. Her excessive drinking may then begin a vicious circle, worth the typical consequences of heavy drinking - eg neglect of appearance, disapproval of family and friends - posing new threats to her sense of feminine adequacy. The new threats can cause her to drink even more heavily, until her non-drinking alternatives for feeling womanly are severely restricted and she becomes completely dependent on alcohol" (Wilsnack 1976 p.48).

The psychoanalysis of women alcoholics sees them as suffering from sex-role conflict (often exacerbated by social factors) as expressed in their inabstinence; and in this sense they are treated as men alcoholics: the problem is inadequate early family experience. But the psychoanalysis of women alcoholics goes further

than this: in addition to manifesting the pathology of alcoholism, women alcoholics possess the essential pathology that all women possess. In women's resolution of the castration complex, they do not develop the superego to as great an extent as men - rather than repressing the id, they project it onto others (men and babies), and are thus incapable of internalising the rule of the father as conscience as men can. For women then, the rule of the father is maintained in their relationship with a man, and their superego is expressed through their abstinence from other men and objects of pleasure. In women's essential incapacity to internalise the id and develop conscience, they must be assisted in overcoming their personal pathology to become civilised by the men on whom they project their natural desires: men, therefore are responsible for encouraging women's abstinence, women's civilisation.

In this tenuous process of obtaining civilisation by abstinence, women require a man in order to compensate for their inherent pathology. Thus, if a woman manifests inabstinent behaviour, by

desiring objects of pleasure other than a man - such as alcohol - she has no means of overcoming her essential pathology. Therefore, born inabstinent women make up for what they lack in numbers by their excessive deviance (Lombroso & Ferrero 1895), and they are doubly damned, both psychiatrically sanctioned, and socially condemned in their sexual/ biological abnormality (Smart 1976):

"As a double exception, the criminal [or alcoholic] woman is consequently a monster" (Lombroso 1895, p152)

Many psychoanalytic studies of women alcoholics take their cue from such an analysis to conceive alcoholism as one manifestation, or symptom, of women's underlying pathology (Karpman 1948, Johnson 1965, Fort & Porterfield 1961, Belfer et al 1971, Boothroyd 1980, Sclare 1970, Winokur & Pitts 1965, Winokur 1969, Goodwin 1971, Rathod & Thomson 1971, Keller 1973, Schuckitt et al 1969, Schuckitt & Morrissey 1979a, 1979b Schuckitt 1983). Thus alcoholism is not seen as the primary disease: women who manifest alcoholic drinking have a more fundamental pathology which is the root cause of their illness.

Schuckitt (1972) perceived alcoholic women as having 'affective disorder' as their primary illness. He argued for a subdivision of patients into

"'primary alcoholics' (those with no pre-existing major psychiatric disorder) and individuals evidencing alcoholism in the midst of other psychiatric problems or 'secondary alcoholics'" (Schuckitt and Morrissey, 1979a p.22)

The "sadness" of "primary alcoholics"

".. probably reflects more than just a reaction to life stress and includes the direct effects of ethanol on the brain, since depression is also seen in 'normal' subjects during experimental drinking situations" (Schuckitt 1983, p.713).

However, the alcoholism of "secondary", or "affective disorder" alcoholics was the symptom of the "underlying depressive illness", that illness being primary affective disorder. This primary affective disorder is diagnosed, significantly, through reduced libido, as manifest in loss of appetite, interest in sex, suicidal reaction and "lack of judgement" (Swinson 1980) - those characteristics which healthy, mature women are psychoanalytically conceived as naturally possessing through the healthy resolution of the castration complex. Thus the finding of many reports, that there is little difference between

the 'sex-role' of alcoholic women and non-alcoholic women (Boothroyd 1980).

"A woman's problem with alcohol, we are told, is a secondary problem: her basic difficulty is perceived to be illness. In contrast, male alcoholism is considered to be a primary disorder... Historically women alcoholics have been considered to be the same as men who are alcoholics, but alcoholism among women is different than alcoholism among men!" (Burns 1979 p.8).

The conception of 'femininity', or sex-role is, therefore, crucial to a psychoanalytic approach to alcoholism. However, within the research on sex-role and the development of alcoholism itself concepts such as 'masculine identification' and 'inadequate feminine identity' have no "common understanding or definition" (Boothroyd 1980, Saunders 1980, Mello 1980, Belfer & Shader 1976). And further, however these characteristics are defined, they cannot be demonstrated at a conscious level, which means that their existence or otherwise can be alleged at 'pre/sub conscious levels'; and thus that certain behaviours - such as drinking alcohol - can be uncritically ascribed to invisible psychosexual personality pathologies.

Despite these problems of definition,

"[Psychoanalysts] have set about describing the true nature of women with a certainty and

a sense of their own infallibility rarely found in the secular world." (Weisstein 1977, p206)

And the fruits of their project are evidenced in the general modern view of women as "weak, inferior, passive, .. dependent, unreliable" (Gelb 1974).

Since the 1920s, however, there has been a steady accumulation of "reliable, scientifically-obtained" evidence¹¹ which clearly demonstrates the invalidity of the psychoanalytic assertion of fundamental differences between women and men. The problem is in the conflation of sex with gender. Maccoby and Jacklin (1974), for example, in their comprehensive review of the psychology of sex difference, concluded that there was "no difference" in terms of intellectual processes such as perception, learning and memory, or in terms of other psychological variables such as sociability, self-esteem, achievement motivation, fear, timidity, compliance or competitiveness. Any marked differences between women and men were conclusively attributed to social rather than psychodynamic factors. Thus the origins of feminine characteristics, supposed to be so crucial in women pathology, are to be sought in

social factors. As I have argued above, the conception of women as naturally abstinent is of central significance in the social distinction between and articulation of the social structures of production and consumption. The psychiatric construction of women in accordance with that provides a *description, but not an explanation* of the specific social relations of abstinence (or the deferral of ones own pleasure to another), and of the specific individual form that abstinence takes.

Furthermore, the social relations of clinical practice describe the positivist assumption of the objective authority of the psychiatrist: since psychiatrists are scientifically trained to identify pathological phenomena which are absolutely invisible to the untrained eye, and psychiatric patients are, by definition, deficient in both consciousness and social/moral conscience, the psychiatrist is socially empowered to treat the patient. And, insofar as psychiatric patients have failed to develop a 'civilised superego', the psychiatrist is socially entrusted with the expert task of assisting the patient to overcome her

pathology by providing, through therapeutic projection, the (temporary) object for her desire. Thus, relationship between the psychiatrist and his patient both reflects and enhances patriarchal gender relations (Chesler 1974, Cooperstock 1977)¹². And thus the treatment provided to women within 'fundamentalist psychoanalysis' is explicitly oriented to their resocialisation into the 'correct' social role: the patient is required to demonstrate her health in her full acceptance of the "often highly ungratifying" role of wife and mother.. or in her achievement of vaginal orgasms (Wolfe 1979). But if the experience of being a woman is cause the pathology in the first instance, then to treat that pathology by reinforcing that experience is particularly serious (Chesler 1974).

Despite this contradiction, the positive belief in the superiority and neutrality and benevolence of the science of psychoanalysis, and in the determined character of human nature ensures the perpetuity of the authority of psychiatric diagnoses. Since the underlying pathology is invisible, and often situated in the past the

diagnosis is unfalsifiable; and, related to this, the patients subordination such that she is unlikely to complain if she feels that the therapy is ineffective.

CHAPTER 3: THE EMPIRICAL CONTINUUM

The positive challenge to the psychiatric identification of the cause of alcoholism in unresolved, invisible psychic conflict came with the identification of alcoholism as a disease in itself. The power of the psychiatrist to discern causes invisible to all but himself put an increasing strain on the positivist principles of the medical model to which it professed to subscribe (Chapter 6). And growing dissatisfaction with both the punitive experience of alcoholism and the costly and unevaluable nature of the psychiatric treatment of alcoholism provided the impetus for the emergence of the Alcoholics Anonymous.

The focus of this new consumer pressure group was on alcohol rather than personality. This reaffirmed the temperance movements concerns that alcohol was a "hazardous commodity", a "demerit good" (Room 1983) that should be handled with care, if at all. This was not a new idea, however

the significance of the idea of the unconscious as the motive force of society had, temporarily, shadowed the attention paid to immediately visible, quantifiable sources of social ill. As far back as 1785 Benjamin Rush, an American physician, had published the first major work on drunkenness as a disease; and in 1788, Thomas Trotter, a Scottish doctor, similarly provided a report of the disease caused by the dangerously addictive substance of alcohol. Huss (1849), a Swedish doctor, was the first to use the term 'alcoholism' to refer to the disease characterised by an irresistible and overpowering desire for alcohol. And, as alcohol was clearly the pathogen, or 'germ' causing the disease, the only cure was total abstinence from alcohol.

Despite its *prima facie* roots in temperance ideology, the resurrection of the disease concept of alcoholism by Alcoholics Anonymous, was not only an attempt to refute the psychiatric definition of alcoholics as pathological individuals, but also to counter the explicitly moralistic teachings of the temperance movement. Alcoholic Anonymous was concerned to provide

public respectability to its members, themselves alcoholics. In opposition to both the psychiatrists and the reformists, Alcoholic Anonymous asserted that alcoholics are neither bad or pathological requiring some form of therapeutic rehabilitation or exorcism, nor passive victims of a demon-in-a-bottle that strikes at random. Rather, alcoholics are special individuals who suffer from an allergy to alcohol. But beyond this assertion of the predicament of alcoholics, AA does not inquire into the "etiology, the causes or the neurophysiology of alcoholism" (Denzin 1987). As, in their voluntary structure and anonymous nature, Alcoholic Anonymous are truly autonomous, as psychiatrists are not, they have no need to subscribe to any positive theory of necessary or sufficient causes. They are therefore free to provide a "theory of alcoholism and an interpretive structure fitted to the experience" of their members. Furthermore, Alcoholics Anonymous' curative prescription is the achievement of total abstinence through self (rather than expert) help.

Alcoholics Anonymous conception of alcoholism as a disease was therefore more pragmatic than explanatory. Furthermore, AA developed a distinctly anti-rationalist approach not only to the explanation of alcoholism, but also the means of 'curing' it. As alcoholic drinking does not occur in the absence of alcohol, the only treatment for alcoholism is total, lifelong abstinence from alcohol. However, as alcoholics are conceived as individuals who have some sort of allergy to alcohol that induces them to drink in an alcoholic manner, the disease of alcoholism is irreversible - abstinence merely arrests the development of the disease. If a recovering alcoholic 'slips' (returns of drinking), the disease process is initiated afresh, since the allergy is reactivated.

"We believe .. that the action of alcohol on these chronic alcoholics is a manifestation of an allergy; that the phenomenon of craving is limited to this class and never occurs in the average drinker. These allergic types can never safely use alcohol in any form at all .. this phenomenon .. may be the manifestation of an allergy which differentiates these people, and sets them apart as a distinct entity... The only relief we have to suggest is entire abstinence" (AA 1976 pp xxiv-xxvi).

"It was [Silkworth's] theory that alcoholism has two components - an obsession that compelled the sufferer to drink against his

will and interest, and some sort of metabolism difficulty which he then called an allergy. The alcoholic's compulsion guarantees that the alcoholic's drinking would go on, and the 'allergy' made sure that the sufferer would finally deteriorate, go insane, or die" (AA 1963).

Hence the AA saying that 'to drink is to die'.

AA did not regard psychiatric intervention as facilitating sobriety, since psychoanalysis was seen as enabling the alcoholic to "blame others, criticise his/her present situation, and project most problems onto childhood":

"... psychoanalysis can provide a most convenient means for the [alcoholic] to keep playing her childhood record again and again while engaging in massive self-pity and studiously avoiding the hard work of taking control of her life and working against her addiction" (Wolfe 1979 p.199).

The only means of recovery, therefore, was to focus on the substance of alcohol through the

"... fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and recover from alcoholism" (Grapevine, quoted in Stafford 1979, p.248).

Unlike the statutory treatment of alcoholism, the 'therapy' is provided by alcoholics to other alcoholics, within closed and anonymous groups. The methods and structures of AA are passed on through an oral tradition, rather than crystalised in an institutional form. The alcoholic takes her

first step in recovery by talking, by admitting her "powerlessness" over alcohol, and that in that powerlessness, her life has become "unmanagable". It is that admission and the sharing of her story of drinking with other alcoholics, who have similar stories, that "puts the alcoholic on a sobriety trajectory".

"AA tells the alcoholic that she is an alcoholic *if she says so*. And, if the drinker agrees, then she has come to the right place, for they will help her not to take a drink today" (Denzin 1978, p.175, his emphasis).

As AA meetings are closed to non-alcoholics, they are unamenable to rational/objective scientific inquiry: recovery is evaluated by the alcoholic herself, within the fellowship of the group, rather than adjudged according to reliable and 'objective' indicators. Furthermore, recovery is conceived not only in total abstinence, but also in a "conversion experience". Once the initial detoxification has "thoroughly cleared the mind and the body of the effects of alcohol" (AA 1976), the mental and spiritual side of the illness must be treated. The alcoholic is encouraged, in admitting her powerlessness, to put her faith in a (non-denominational) "Higher Power", to believe in a power greater than herself. It is in this

spiritual aspect that the alcoholic, and AA, affirms the existence of alcoholism whilst saying that the cause of the disease cannot be proven. And it is by this renunciation of rational induction that AA seek to reduce the stigma of alcoholism, since by this perspective, it cannot be regarded exclusively as a disease of the will (Stafford 1979). And it is by this distinctly irrationalist perspective that AA challenges the monopoly of the Experts.

The problem for the disease concept of alcoholism came when the attempt was made to rationally institutionalise it: to make it scientifically respectable. As the twentieth century progressed, collaboration between the medics and AA seemed a potentially productive way of dealing with the tenacious social ill of drunkenness. Jellinek expressed the intellectual fruit of this liaison in his book The Disease Concept of Alcoholism (1960). He argued that the term 'alcoholism' was used to relate to so many and various patterns of behaviour that it lost all useful meaning. Consequently, he identified 5 types of alcoholism "that may come at all into consideration as

disease processes or symptoms of disease
processes":

"Alpha alcoholism represents a purely psychological continual dependence or reliance upon the effect of alcohol to relieve bodily or emotional pain. The drinking is 'undisciplined' .. but does not lead to 'loss of control' or 'inability to abstain'... The damage caused by this species of alcoholism may be restricted to the disturbance of interpersonal relations... but not the disturbances due to progressive withdrawal of alcohol. Nor are there any signs of a progressive process. [Alpha alcoholism] may be regarded as a symptom of the pathological conditions which it relieves. This species of alcoholism cannot be regarded as an illness per se."

"Beta Alcoholism is the species of alcoholism in which such alcoholic complications as polyneuropathy, gastritis and cirrhosis of the liver may occur without either physical or psychological dependence upon alcohol. The incentive to heavy drinking that leads to such complications may be the custom of a certain social group... Withdrawal symptoms .. do not emerge."

"Gamma alcoholism means that species of alcoholism in which (1) acquired increased tissue tolerance to alcohol, (2) adaptive cell metabolism .. (3) withdrawal symptoms and 'craving' ie physical dependence, and (4) loss of control are involved. In gamma alcoholism there is a definite progression from psychological to physical dependence and marked behaviour changes."

"Delta alcoholism shows the first three characteristics of gamma alcoholism .. [but] instead of loss of control there is inability to abstain. In contrast to gamma alcoholism there is no ability to 'go on the water waggon' for even a day or two without the manifestation of withdrawal symptom; the ability to control the amount of intake on any given occasion, however, remains intact."

"Epsilon alcoholism .. is periodic alcoholism." (Jellinek 1960 pp 36-39, emphasis in the original).

Of these 5 "species" of alcoholism, Jellinek argued that only "gamma" and "delta" alcoholism were, in fact, 'disease forms' of alcoholism. However, Jellinek deliberately avoided defining 'disease' *per se*, opting (in the tradition of the AA) for the pragmatic definition of disease as "what the medical profession recognizes as such" (1960). In accommodating this pragmatic, Jellinek was led to an operational definition of the disease of alcoholism as "loss of control", by which he meant the drinkers inability to control her drinking once started ("gamma alcoholism"), or the drinkers inability to abstain from drinking alcohol ("delta alcoholism"). He noted that these two "species" of alcoholism were, in fact, forms of drug *addiction*, defined then by the World Health Organisation as periodic or chronic intoxication which is detrimental to the individual or society and produced by the repeated consumption of a drug.

The problem for Jellinek came when, in observing that only about 5% of individuals drinking alcohol develop 'disease forms' of alcoholism, he found no

".. specific personality trait or physical characteristic which would inevitable lead to excessive symptomatic drinking" (Jellinek 1952, p683)

He was left with no positive explanation for the development the disease of alcoholism, and took recourse in the notion that some mysterious "organic lesion or physiological anomaly" (Jellinek 1960) caused alcoholism. Whatever this was, it engendered

".. a disease process ... irrespective of whether the lesions or physiological anomalies are pre-existent to 'alcoholism' or acquired through initial heavy alcohol intake" (Jellinek 1960).

Thus Jellinek encountered the general confusion that seems to be characteristic of the scientific attempts to delineate specific causes of alcoholism. The fundamental problem is in the difficulty of separating cause from effect, or in assuming that observed correlations (or coincidences) are causally related¹. In believing that each illness possesses it's own unique and specific cause, which then serves as the basis for the differentiation, classification and treatment of the illness, Jellinek logically had to assert

that alcoholics were qualitatively different from non-alcoholics. In striving to move away from the notion that the individual expressed alcoholism as a symptom of her underlying pathology to a notion that the individual simply possessed alcoholism, Jellinek merely concluded that the individual was pathological, whether alcoholism was the symptom or the cause.

In his concern to effect change for the better for the alcoholic, Jellinek conformed exactly to the principles of positive science which inhere in clinical practice. Positive medical intervention assumes that there are discrete distinct diseases which involve a *qualitative break* in functioning between healthy and pathological individuals, as opposed to a continuum, in which illness is a matter of quantitative difference from health (Busfield 1986). In the case of alcoholics, that qualitative difference lay in the "mysterious anomaly".

As the 1960s progressed the notion that there was a real (if unidentifiable) difference between alcoholics and non-alcoholics was steadily eroded.

Thousands of pounds worth of experimental and clinical research had failed to identify any personality defect or biochemical anomaly specifically engendering alcoholism. Positive science seemed to have lost its way in a complex cluster of possible causes and of degrees and types of harm. Therefore, as the disease concept of alcoholism gained some scientific and medical credibility it was simultaneously discredited in the absence of positive evidence of both a distinct alcoholic personality and of a reliable disease agent. Furthermore, the social and political advantages of positively establishing alcoholism as a disease were also disintegrating. The disease of alcoholism became just as stigmatised as earlier conceptions of inabstinence, thereby inhibiting voluntary intervention in drunkenness by drinkers and non-specialist, non-statutory personnel. And the concept of disease itself, as a means of conceiving the distinction between health and illness was itself increasingly challenged.

Much of the criticism of the idea that alcoholics were distinctly different from non-alcoholics was

in terms of the methodological problems of clinical studies of alcoholic groups. Earlier work was increasingly regarded as focusing on a "rather exclusive" category of drinker, which may not even be representative of all chronically damaged drinkers since it was generally based on populations such as hospital and prison inmates and AA members. And Jellinek's work, which hitherto defined diagnostic patterns of alcoholism, was exposed as being based on retrospective questionnaires from Alcoholics Anonymous members (many of which were not returned). Thus Jellinek's formulation of the disease concept of alcoholics was questioned as being representative of even AA members.

As the research on drinking and drunkenness broadened its sample populations the persistent lack of the identification of shared etiological and developmental characteristics among all defined alcoholics prevailingly challenged the notion that alcoholism was a distinct and unitary phenomenon. In observing that

"Alcoholics are different in so many ways that it makes no difference" (Keller 1972)

Keller (1972) suggested the following "law" in the diagnosis of alcoholism:

"The investigation of any trait in alcoholics will show that they either have more or less of it" (Keller 1972).

In addition to questions regarding the general reliability of earlier studies of alcoholics, methodological criticism focused specifically on the need to distinguish association or correlation from causal relations (Pattison et al 1977).

"The bad effects of alcohol, which develop as consumption increases, cannot be interpreted as 'proof' that all excessive drinkers have some peculiar personality or physiological make-up in the first place" (Shaw et al 1978, p.53).

And survey research in the 1960s and 1970s pointed with increasing weight to the notion of a continuum of 'alcoholic' individuals:

"There are alcoholics who are down and out homeless vagrants, ill-kempt, verminous and reeking of drink. For every one of these there are probably a hundred or more who continue to occupy their usual place in society as husbands, fathers and workers in various fields; They are generally indistinguishable by social criteria from the rest of us" (Davies 1974 p.197).

Within the drinking continuum people who were diagnosed alcoholic appeared at the extreme end rather than being distinctly different from others. And researchers began to discern "two worlds of alcohol problems" (Room 1977). Firstly,

the world of very damaged alcoholics, who appeared in the early research on alcohol problems; and second, the world of the people in the general population surveys, who did not seem to be 'real' alcoholics, but who, nevertheless, had 'real' alcohol problems (Pattison et al 1977).

Furthermore, the evidence indicated that certain physiological, psychological, sociocultural and environmental factors may increase an individuals susceptibility to the development of alcohol problems (Pattison et al 1977). The breadth of such possible determinants and of the nature of alcohol problems, however, was such that the post hoc labelling of individuals as alcoholics would be of "little utility and may even worsen alcohol problems". Clinical diagnosis was seen by many to serve as a 'self-fulfilling prophecy', defining, and thereby constructing individuals as distinct alcoholics (Chapter 5).

The steady accumulation of evidence positively refuting that alcoholism was a distinct disease, and that diseased individuals could be positively distinguished from healthy individuals led to the development of the notion that individuals have

differential susceptibilities to alcoholism (or alcohol-related problems) according to their particular situation. The egalitarian principles of the Social Contract emerged again, this time in the form of individual susceptibility to alcoholism. Alcoholism became, if you like, a universal equivalent, like money, possessed by individuals in greater or lesser quantities according to their position within society². The concept of an alcoholic continuum - or of a continuum of alcohol-related problems - was conceived in which the alcohol is abstracted from the individual in order to maintain qualitative individual equality.

With the demise of the notion of qualitative difference between alcoholics and non-alcoholics came the demise of the other key aspect of the disease concept of alcoholism: the notion that alcoholism was a progressive and irreversible disease that followed an inexorable development through a distinct series of phases, and that alcoholics were characterised by their experience of an irresistible craving for alcohol. Two years after the publication of Jellineks Disease Concept

of Alcoholism. D.L. Davies (1962) reported his findings that seven out of 93 alcoholics had returned to normal drinking after a short period of abstinence. He contended that this indicated that the individuals experience of "loss of control" was a subjective phenomenon, rather than an objective indicator of essential pathology. Such a finding was sufficient to question the whole rationale of the disease concept of alcoholism (Shaw et al 1978). The empirical possibility of recovery from alcoholism and the inference that alcoholism was a subjective experience rather than a matter of fact was met only by assertions of the 'reality' of alcoholism - that no 'real' alcoholic could 'recover' to drink normally (Edwards 1970).

A flurry of further research began to support Davies' (1962) finding that alcoholism - as uncontrolled drinking - was reversible (Mansell Pattison 1966): the experts began to believe that alcoholism could not, after all, be sharply and individually defined. And, as the irreversibility of alcoholic drinking was challenged so too was the notion of the "loss of control" of drinking

(Parades et al 1969, Mello and Mendelson 1965).

The developing paradigm for understanding drinking and drunkenness was that of a continuum - not only across many individuals, but within the same individual. The same individual may, at different points in her life, experience abstinence, normal drinking, alcoholic drinking and all the stages inbetween. And in 1976 the World Health Organisation rejected the disease concept of alcoholism in favour of the notion of "alcohol dependence syndrome".

The idea of a syndrome, rather than a disease, freed the treatment of the problem from the constraints of etiology:

"A syndrome is a clinical and intuitive cluster. No assumptions need be made at the empirical stage as to the causal nexus, as to why these phenomena cluster in such a fashion, as to 'the pathology'" (Edwards 1977, p.137).

In this way, the clinical focus was removed from both personality and alcohol as pathogens. The emphasis was placed on the relationship between the physiological and psychological experience of alcohol, in particular the extent to which the individual sought "relief or avoidance of withdrawal symptoms by further drinking" (Edwards

1977)). Such "aversion avoidance" drinking indicated that problem drinking was *learnt* as a strategy to avoid withdrawal symptoms. Alcoholism, therefore, was a cognitive phenomenon - dependence on alcohol was a learnt behaviour. And, as such that 'problem' could be un-learnt. The treatment focus, therefore, was on drinking *per se*. Cognitive psychology restored the optimistic mood of positive intervention in drunkenness.

"Drinking is a discrete and observable behaviour; it is not difficult to define, and with the help of technology, it's occurrence can even be determined retrospectively. We can readily measure aspects of drinking such as its frequency, distribution over time and amount consumed. Because of the quantifiability of drinking we can make comparisons within and between individuals and populations. And, perhaps most importantly, we have a firm basis for determining whether or not a particular operation has any effect on drinking behaviour" (Cappell 1977 p.100).

The emphasis was removed from the search for final causes, and focused instead on the behavioural strategies that maintain drinking behaviour. Concentration was on observable behaviour - drinking - and on those environmental conditions that elicit and/or maintain alcoholic consumption. In essence,

"Alcoholism is viewed as a conditioned behavioural response that can be 'unlearned' though the appropriate modification of

environmental stimuli and reinforcement situations" (Armor et al 1978, p.22).

The simplest behavioural approach follows the Pavlovian model: alcoholic behaviour was seen as both caused and maintained by the simple association of ingestion of alcohol with some sort of positive, rewarding experience, such as the alleviation of depression. Equal emphasis was placed on both the maintenance of alcoholic drinking and its cause, unlike Jellinek's habituation hypothesis, and thus providing for the possibility for changing drinking habits. Consequently, the treatment goal was not necessarily total lifelong abstinence, rather, it required changing the "stimulus value" of alcohol from positive to negative, simply by pairing the consumption of alcohol with aversive consequences, for example through the use of disulfiram³. The "patient" learns to associate the consumption of alcohol with (the experience or threat of) extremely unpleasant sensations rather than the avoidance of unpleasant sensations, and thus stops drinking.

Such analyses of drinking generally observed that excessive drinking was maintained through positive

reinforcement deriving from the depressant and anaesthetic properties of alcohol on people in stressful situations (Mayfield 1968, Bandura 1969, Williams 1966). Thus individuals drank because the consumption of alcohol was immediately followed by a reduction in "anxiety, psychological stress or tension". As excessive drinking continued, metabolic changes became the basis for the "second maintaining mechanism": the experience of aversive physiological reactions such as tremulousness, nausea and vomiting on withdrawal of alcohol. The individual became "compelled" to consume large amounts of alcohol to allay withdrawal symptoms and to prevent their recurrence. Thus drinking was automatically and continuously reinforced within the individual.

Significantly, the psychological conception allowed for a behavioural continuum of alcohol dependence. Firstly, the reinforcement of learning was conceived as partial, so that a behavioural process may be learnt without reinforcement in every instance. Thus an individual may learn that alcohol temporarily relieves depression, for example, even if it does not do so on every

occasion. Secondly, an operant analysis involved probabilities, rather than immutable laws. So the consumption of alcohol in order to relieve alcohol withdrawal symptoms will gradually become more probable than other responses to the discomfort of withdrawal - a hangover. And finally, the operant concept of a "gradient of reinforcement" explained ostensibly paradoxical behaviour - such as the repetitive consumption of a substance which appeared to others to be damaging to an individual's life. The concept of a gradient of reinforcement included the notion that a reward which immediately follows a particular behaviour is more effective in shaping behaviour and making it more or less probable in the future than a reinforcement that occurs later. Thus the immediate alleviation of, say depression, upon the consumption of alcohol was a more effective reinforcer of behaviour than the later experience of withdrawal symptoms (Orford 1977).

"Motivation" was a key variable within the concept of the gradient of reinforcement of dependence; it was conceived as an "emotional and cognitive attachment of the stimulus associated with the

behaviour". This registered a shift in emphasis from the rational utilitarian conception of will power, to a recognition of the significance of possibly irrational factors, such as emotion. Furthermore, the concept of "motivation" included environmental and interactive factors, more than the isolated behavioural instance. Davies (1982) described the significance of social and environmental factors in the assignation of will-power to an action by suggesting the example of an individual crossing a busy street. In the absence of any knowledge of the individual circumstances (history, emotions etc.) such an action would be unlikely to be regarded as involving will-power. However, some knowledge of the individual circumstances of the action - such as the recent serious injury of the pedestrian during such an activity - may result in the attribution of will-power to the individual in question. The positivist project in isolating phenomena in order to understand them would provide no such understanding in a case such as this, since it allowed for no conception of the specific environmental circumstances of the individual.

The concept of "motivation", alternatively, allowed for some interaction of the individual with her environment:

"Circumstances must be such as to be motivating, in order for a person to show motivation; the idea of will-power, by contrast, implies that we did something all by ourselves (people like the idea of will-power precisely *because* it is such a conceited and egocentric notion)" (Davies 1982, p.14, his emphasis).

Thus if an individual was to be "motivated", their circumstances must be changed: motivation emerged from the "interaction of particular people with particular situations". And the behaviourist analysis of alcoholism provided much evidence that an individual's "motivation" was an important determinant in the success of treatment (Orford 1977, Davies 1982). Thus psychological intervention in problem drinking was extended to processes beyond physical aversion therapy:

"What we need is research on how to help alcoholics *reprogram their lives* so that other more *socially desirable* factors play a dominant role in directing their lives" (Dewes 1972, p.1046, my emphasis).

Consequently, in order to 'treat' excessive drinking, the alcoholic was to be motivated through the identification of goals which were both appealing and realistic to them, and which they could not achieve because of their drinking

(Davies 1982). Thus the motivation to drink was replaced by the motivation to achieve other goals; and thus continued drinking came, through successful treatment, to be seen as a continued source of frustration rather than a periodic source of satisfaction. The pathological alcoholic was thereby transmogrified into an individual who was mistakenly motivated. The conception of a diseased individual was the conception of an abnormal individual in a specific pathophysiological sense, since she was observed as failing to modify her behaviour in aversive circumstances. Furthermore, insofar as earlier, non-psychological treatment conceived the disease of alcoholism as irreversible, the alcoholic individual within such treatment was seen as deprived of positive reinforcement: the motivation to make changes for the better since she had no control over "the causes and progression" of her pathology.

Following this argument, then, the humanitarian purposes of the disease concept of alcoholism - to remove the stigma of alcoholism by making it analogous with, say, tuberculosis - also served to

remove all sense of individual control over the 'condition'. The 'problem' of drunkenness according to both psychological and psychoanalytic analyses was internal to the individual; however the psychologist contended that since the psychoanalyst treated it in a "highly external" manner, and "the disease model thus excluded the patient from his own cure, and did not result in a motivating interaction between patient and therapy". The alcoholic patient of the psychologist, therefore, was to be motivated to control her drinking by feeling in control of her therapy: the therapeutic relationship was now conceived as one of a partnership - patient/client and doctor united against a common foe.

What the expert lost in indubitable authority and in the assertion of the patient as a partner in her own treatment, however, was gained in the broadening of the definition of individual in need of expert assistance. As the concept of "dependence" on alcohol replaced that of "loss of control" over alcohol, the jurisdiction of the experts expanded from the phenomena of psychological "craving", "compulsion" and the

"pathological need" to drink, to encompass physiological and "even social dimensions" related to alcohol use (Shaw et al 1978). And the expertise of the doctor (the psychologist in this case) was still required in the discernment of 'real' normality from the appearance of normality: individuals who did not overtly appear to have a 'problem' may,

".. be drinking in a manner which is overtly 'normal', whereas close questioning will reveal that his subjective relationship with alcohol is still far from normal - he wants to go on drinking, but with reluctance stops himself" (Edwards 1977, p.150).

So the necessary expertise of the doctor was not only maintained, but extended beyond expressly pathological individual phenomena.

The individual and behavioural continua of alcohol dependence, therefore, saw the return of the profound utilitarian equality of the eighteenth century: all individuals were conceived as equal in their desire to avoid aversive experiences. And in the reassertion of this rational pleasure principle, individuals who drank in response to unpleasant stimuli (physiological, psychological or social) were regarded as normal in their motivation (Higbee 1977). The problem was simply

that they had committed themselves to a damaging means of relief from unpleasure, and it was the psychologists task to modify the individuals "maladaptive response to stress situations" (Armor et al 1978).

The new paradigm of psychological clinical practice, as well of theory, therefore, embalmed the utilitarian social contract. The assertion of the patient as an equal partner in her treatment for "alcohol abuse" extended the contract form of the market to medical practice.

" The contract between practitioner and patient, arranged on a one-to-one basis, is treated as a free contract between both partners that either may terminate. This, it is argued, (in conjunction with the adequate training and licensing of practitioners) guarantees the quality of practice and ensures that the patients interests will be served, since patients may turn elsewhere if they are dissatisfied" (Busfield 1986, p.21).

Free and equal individuals, then, comprised the substance of the clinical contract, since

".. doctors treat only those who have decided .. to consult them" (Busfield 1986, p.25).

If the clinical contract was coercive, rather than voluntaristic, the patients commitment would be lacking and the treatment, lacking in the motivation of the patient, would be unsuccessful.

Patient choice of (and hence of commitment to) treatment regime thus became the key to the successful treatment of drinking problems, since if the individual was not committed they would not modify their behaviour (Heather 1980).

The conception of a drinking continuum broadened the jurisdiction of the medical/psychiatric/psychological experts to include a newly defined population of problem drinkers, who did not manifest the more florid symptoms of alcoholics. This expansion, facilitated by an operant analysis of drinking, provided an alternative to treatment in the form of total abstinence (or death). The rational principle of aversion avoidance allowed for the possibility that total abstinence itself was aversive, and thus demotivate problem drinkers.

"Assuming that the client's wishes are the touchstone of goal selection, we can expect that *at least* 20% - 30% of *hospitalised* alcoholics will opt for controlled drinking. Assuming that non-hospitalised out-patients will have less serious problems, and hence will be more likely to choose controlled drinking, this proportion is liable to be much greater within a comprehensive service, and may in many cases constitute a majority... and .. as the myths about abstinence become dispelled, this number will increase" (Heather 1980 p.14, his emphasis).

The new 'treatment modality' of controlled drinking was premised on the rationalist assumption that all individuals (normal and deviant) learn aversion avoidance strategies. Individual differences were conceived through the concept of the gradient of reinforcement, wherein particular individual circumstances (psychological, physiological and social) determined the extent to which alcohol was chosen as the means of coping with the existential problem of stress. As all individuals experience life stress (Higbee 1977), all individuals were qualitatively similar.

Alcohol dependence syndrome indicated the steepening gradient of reinforcement towards drinking as the primary means of aversion avoidance. The problem here was that as drinking increased, the quantity of aversive experiences increased thereby steepening the gradient of reinforcement towards alcohol - and thus the problem drinker sets up a vicious circle for herself. Psychological treatment, however, aimed to provide the means for breaking out of the vicious circle by gradually motivating the problem

drinker to alternative, healthier means of aversion avoidance: if the individual was drinking due to marital pressures, for example, she would be introduced to the idea that her problem drinking was exacerbating her marital pressures and she was trapping herself in the vicious circle of alcohol dependence. Thus, in order to avoid the unpleasant experiences of marital dysfunction, she should avoid drinking and seek more functional means of resolving marital stress. As the client becomes committed to alternative aversion avoidance strategies, she would gradually experience a gradient of reinforcement away from drinking and learn to control her drinking.

As commitment was the key to behaviour modification, the intervention of the psychologist was kept to a minimum in most cases. The very act of asking for help was regarded as proof of the individuals initial commitment to the idea of alternative aversion avoidance strategies. As the psychologist could catalyse controlled drinking during the first visit in more cases the costs of intervention were kept down (Heather 1986), there were "significant reductions in consumption at low

risk-levels", and a reduction in the number of individuals who were experiencing alcohol dependency at the far (alcoholic) end of the continuum. The utilitarian pleasure principle is redeemed: as more individuals are happy and healthy, society will be happier and healthier.

When women are brought into the picture, however, the utilitarian continuum emerges somewhat skewed. Insofar as all individuals experience life stress, they will equally seek relief. They will differ only in the form of relief that they seek. A significant amount of research has been done however, which indicates that women experience significant dysphoria and anxiety in relation to their menstrual cycle (Steiner & Carroll 1977, Moos 1969, Wilcoxon et al 1976, Dalton 1964). Life stress then, with regard to individual physiology at least, is not gender neutral: women, by these analyses, have a greater pre-disposition to dysphoria and anxiety than men. And, insofar as alcohol is regarded as a means of relief from the aversive experiences of a female physiology, women are conceived as having a greater pre-disposition to problem drinking than men (Podolsky 1963,

Belfer et al 1971, Lisansky 1957, Wilcoxon et al 1976).

Furthermore, research into behavioural effects of intoxication consistently show that a given dose of alcohol calculated on body weight will produce a significantly higher blood alcohol level in women than in men. True to the principles of qualitative equality embalmed in positive approaches, this finding is explained in terms of the quantitative differences between women and men: women's bodies contain proportionately less water, but more adipose (fatty) tissue than men. This is because more water is contained in muscle tissue (more predominant in men's bodies) than in adipose tissue (predominant in women). The total body weight of men contains approximately 55% - 65% water, whereas that of women contains 45% - 55%. Since alcohol is distributed throughout the body in proportion to the water content of the body tissues, the alcohol in women's bodies is less diluted than in the bodies of men. The higher concentration of alcohol in women's bodies after consuming less alcohol than men makes women both more intoxicated than men on consuming the same

amount of alcohol, and also more vulnerable to physical damage from alcohol such as cirrhosis of the liver (Wilkinson 1980) and brain damage (Crawford & Ryder 1986). And, as high blood alcohol levels are associated with low levels of oestrogen and progesterone, women who drink alcohol during the premenstual period are likely to experience greater intoxication than at other phases of the menstrual cycle (Jones & Jones 1976a, 1976b). "Self-medicating" women, therefore, who drink to relieve pre-menstrual dysphoria and anxiety (attributed to low oestrogen levels) are both more susceptible to physical damage, and more likely to learn that alcohol is a particularly effective form of aversion avoidance strategy (Mello 1980). Women are therefore conceived as having a greater physiological predisposition to alcohol dependency syndrome than men. Thus, in behaviourist terms, at least, not only is physiological stress not gender neutral, but the physiological effects of alcohol are not gender neutral. Stress and the detrimental effects of alcohol are not, therefore, randomly distributed throughout the individual continuum: clearly gendered patterns are positively evident.

Insofar as women are disadvantaged by the vagaries of their bodies, they can be re-advantaged by restoring their biochemical equilibrium. Thus the suggestion that hormone (oestrogen) supplements may be beneficial in the treatment of both the craving for alcohol and the depression produced by alcohol consumption (Jones & Jones 1976a). Women's rational equality is compromised by the vagaries of their bodies, but medical intervention promises to restore the balance. The contraceptive pill, for example, stabilises oestrogen and progesterone levels throughout women's menstrual cycle; however it increases the overall experience of negative affect and slows down the metabolism of alcohol (Jones & Jones 1976a): women's capacity for rational equilibrium continues to be compromised by their bodies. The overall increase in negative affect due to such intervention means that women taking oral contraceptives are more likely to make use of aversion avoidance strategies such as drinking; and further, since their metabolism of alcohol is impeded, they are more susceptible to physical damage than other women (who are generally more susceptible to physical damage and

alcohol dependence syndrome than men). Women, therefore, who are both alcoholically inabstinent and sexually inabstinent (in seeking sexual pleasure, but not reproduction) are doubly damned. The only answer is for women to remain abstinent.

Several other researchers, however, have countered the reduction of women's affective state (mood) to their physiology. The notion that the biochemistry of menstruation causes depression, anxiety, impaired concentration etc. has been challenged by several writers (Weideger 1978, Ehrenreich & English 1973, 1979, Paige 1973) who contend that it is the social beliefs about menstruation that effect women's subjective response to menstruation. Menstrual dysphoria and anxiety, therefore cannot be regarded as objective states that can be positively associated with the consumption of alcohol. Furthermore, and perhaps more condemning of the behaviourist conception of alcohol abuse, behaviourist research has shown that alcohol does not invariably relieve negative affect. Some studies of individuals actually drinking have shown that the experience is "the

opposite of stress reduction" (Mello & Mendelson 1978).

"... alcohol abuse may distort the simplest pleasures of intoxication and transform the anticipated rewards of social drinking into their antithesis... As direct observations of the effects of alcohol intoxication replace inferences based on self-reports obtained during sobriety, many traditional beliefs are reevaluated and gradually replaced with new and different concepts" (Mello 1980, p.287).

Earlier psychological research failed to engage with the actual behaviour in question, relying, instead, upon retrospective reports by alcoholic drinkers. As such, this research must be invalid by behaviourist principles (Mello & Mendelson 1978). Subjective retrospective reports are coloured by *expectations* of the effects of alcohol, rather than the actual effects of alcohol, and therefore prove only that the widespread belief that alcohol reduces feelings of anxiety and depressions is self-perpetuating - that it acts as a self-fulfilling prophecy (chapter 5).

"Although the effectiveness of alcohol as an antidepressant appears to depend on the drinkers expectancies rather than on any intrinsic pharmacological actions, nonetheless the anticipation of relief from depression and anxiety probably is an important factor in the initiation of drinking episodes. This expectancy about alcohol's effects may be an important facet

of problem drinking in women..." (Mello 1980, p.291).

The behaviourist paradigm in itself therefore may be seen as reinforcing the erroneous belief that individuals drink in order to relieve aversive affective experiences. Thus the source of motivation that is significant in determining the direction of the gradient of reinforcement of drinking is seen to be social not only in terms of the interaction between the treatment modality and the problem drinking patient/client, but also in terms of wider social factors (Cressey 1971). The experience of negative affect, therefore

"... cannot be understood apart from the kinds of activities and challenges that women face in their environments ... [there is not a] uniform, monolithic effect of either the menstrual cycle or associated bodily changes upon women's moods and activities" (Wilcoxon et al 1976, p.412 - 413).

The commitment of the patient/client to positive change is crucially influenced by the extent to which they feel capable of making that positive change. If an individual repeatedly experiences that she cannot control a situation, she is likely to "learn helplessness" (Seligman 1976).

Psychological research has found that not only does the propensity to drink increase as "learned helplessness" is experienced in the form of

helplessness" is experienced in the form of anxiety in the face of an uncertain, uncontrollable future (Lisman 1980); but also that depression (independent of alcohol consumption) is likely (Seligman 1976). These two variables dependent on learned helplessness increase the likelihood of drinking. And subjective social variables thus come within the scope of psychological analysis and treatment of alcohol abuse.

Social class, quality of family life and employment seem particularly significant in the research on learned helplessness (Armor et al 1978, Pemberton 1967, Sclare 1970, Edwards et al 1972, Shaw 1980, Schuckitt 1972): working class married women who are looking after young children at home without alternative employment and without a supportive partner are consistently identified as those most at risk of depression through learned helplessness (Brown & Harris 1978). In addition to the more objective social factors (such as poverty, see chapter 5) in the development of learned helplessness, the individual's identification of the cause/s of her

predicament is significant (Levis 1976): those individuals who attribute their situation to outside interference rather than to themselves are less likely to "learn helplessness":

"If one attributes past outcomes to luck (a variable cause) then these outcomes will not influence one's expectancies in future situations, but if one attributes past outcomes to ability (a stable outcome) then one's expectancies for performance in future situations will shift in the direction of outcome. Results suggest that stability of attribution mediates the degree of influence that past outcomes exert on expectancies for performance in future situations" (Miller & Norman 1979, pp.109-110).

The nature of attribution, however, is not gender neutral. Women tend to attribute the causes of their successes and failures - of their life - to external factors, beyond their control⁴. Men however, generally have a more internal "locus of control" (Rohsenow & O'Leary 1978). And while women's "locus of control" remains external, they will feel unable to effect change in their lives, and thus unable to control their drinking themselves. The treatment of women who are depressed and who abuse alcohol, therefore, is to expel learned helplessness by facilitating the development an internal locus of control. One way of doing this, for example, would be to provide out-patient clinics as an alternative to in-

patient treatment, which enable women to decide themselves if and when to come for treatment (Knowicke & Hopper 1974). Thus, insofar as the problem drinking client has learned helplessness through role restriction (Brown & Harris 1978) and the general lack of opportunities, the element of individual free choice of treatment modalities is a key factor in the psychological prognosis.

Free choice, however, cannot deal with the reinforcement of an internal locus of control through loss. As an individual experiences "exit events" such as the death of a loved one, children leaving home, a major marital disappointment or an enforced move (Brown & Harris 1978), any pre-existing feeling of helplessness is consolidated, since no choice is (ontologically or perceptively) possible. Non-psychoanalytic (psychological) research on depression has repeatedly shown that loss is a predominant feature of life events that trigger depression (Brown & Harris 1978). And further, that loss is a precipitating factor in the development of problem drinking (Breeze 1985, Lindbeck 1972, Lisansky, Corrigan 1980, Curlee 1969, 1970, Shaw 1980, Plant 1980).

The most comprehensive survey to date of women's drinking patterns in the Britain (Breeze 1985) found that alcohol consumption was related to life stress, in particular, "severe" events with "marked or moderate long term threat focused on the woman herself or jointly with someone else" (Brown & Harris 1978). A common feature of these "threat" events was a loss to the person concerned.

"The heaviest drinkers were .. more likely to be recently separated (1 in 5 being so)... Nearly 40% of the heaviest drinkers felt often felt that no-one understood their problems, compared to less than 20% of the women at the other consumption levels. In the whole sample women who felt that no-one understood their problems were more likely than other women to report a 'threatening' event and the heaviest drinkers were most likely to have experienced *both* isolation and .. threatening events" (Breeze 1985, p.49).

The classical behaviourist paradigm that the individual may learn to regain control over his drinking by reversing the gradient of reinforcement away from alcohol is insufficient, therefore in the case of women. Rather than dependency on alcohol being the problem for women, *dependency per se is identified as the key issue* (chapter 5). The argument is that if women were not so dependent on others for their self-

validation they would not be so predisposed to drink in the face of loss/threat events. The focus of expert psychological attention therefore, shifted away from the relationship between the cognitive response to physiological change (upon drinking) to the development of general cognitive dependency in women. And thus to general processes of socialisation (chapter 5).

The cognitive development approach to socialisation allows that particular areas of learning may be automatically denied to women (Burtle 1979b). Insofar as women develop the feminine qualities of "trust", "intimacy" and "generativity"⁵, they express themselves in relation to others. However, as feminine socialisation denies the development of the "masculine" qualities of "autonomy", "initiative" and "industry", women do not realise self-control or external ambition. Thus the development of women's external locus of control, and thus the greater cognitive vulnerability of women to uncontrolled drinking.

Insofar as women seek relationships with an Other through which they may express their satellite self, they find it difficult to conceive of themselves as individuals or act autonomously or independently. And should they experience a threat to, or lose their relationship with the Other, they experience dissolution: bereft of that interpersonal identity such a woman will be immobilised and ineffectual. Thus the risk to women in experiencing "loss" or "threat" is not, in the cognitive development paradigm, conceived as material (involving physical danger or economic impoverishment, for example), but as entirely internal: lacking an Other, women lack all substance⁹.

And the experience of loss of self (through loss/threat to others) not only consolidates women's external locus of control, but facilitates the identification of alcohol as a key external agent of control and hence of definition: in consuming alcohol, the woman *becomes something*. However, the consumption of alcohol, unlike significant "exit events" is self-administered.

Drinking provides women with sense of
instrumentality

".. of *doing*, of acting, and of directing the
course of her life, however maladaptively"
(Burtle 1979b, p.159).

And insofar as the self-administered consumption
of alcohol is experienced as being "uncontrolled",
the experience of external events as
"uncontrollable" is internalised. And the drinking
woman experiences a rational continuity between
her external and her internal experiences. She
begins to experience some consistency, and is, at
last, able to rationally predict life events. The
drinking woman has, therefore, achieved some
equilibrium by confirming her individual
implication in external events. The alcohol-
induced continuity between external and internal
control is experienced as guilt - not only in
terms of loss/threat, but also in terms of the
drinking itself. Thus the generally low self
esteem of women alcoholics is consolidated.

The psychological solution to uncontrolled
drinking through the establishment of a free and
equal contract between psychologist and client,
and the provision of choice of treatment

modalities cannot, therefore, deal with drinking as a confirmation of women's experience of general external determination. However, the movement of psychologists attention from the internal individual content of drinking (cognitive response to physiological change) to the external individual content of drinking (socialised cognitive dependency) enabled expert psychologists to extend the continuum of drinking in response to aversive experiences such as depression, to the cognitive development of low self esteem and external loci of control. And in the conception of women as participants on the continuum of drinking alongside men, women's greater propensity to uncontrolled drinking was seen as more a matter of the development of dysfunctional beliefs about self and society than of intrinsic pathology. Feminine cognitive development requires, to a considerable extent, the development of socially dysfunctional beliefs.

Alcoholic drinking, as a dysfunctional behaviour motivated by dysfunctional emotions, therefore, was not regarded as being maintained by the material substance of the individuals situation;

but rather by what the individual believes about her situation. Irrational beliefs are especially fostered in women through a process of "continuous self-reindoctrination" which profoundly effects their self esteem (Wolfe 1979). The "number one" irrational belief that contemporary women hold is the

".. dire necessity to have the love and/or approval of every significant person.." (Wolfe 1979,p.201)

Unless they have that love and approval they believe that they are inadequate. And women develop alcoholic drinking through feeling worthless and unable to function in their lack or loss of a man. In the irrational belief that they are inadequate without the love and approval of a man, women are seen to be escalating a "preference" for having a relationship into a "demand". And it is this irrational demand, premised upon an irrational belief in love and approval that is the source of their anguish and depression, rather than the actual event of rejection⁷.

Secondly, women's "irrational belief" in their guilt and self-blame is seen to prohibit women's

acceptance of their errors and fallibility, and therefore they cannot forgive themselves for any real or imagined faults^a.

"Taught by their culture to value themselves for their ability to serve and be attractive to men, and told by popular opinion and much of the psychological literature that if kids turn out poorly, mother is to blame, women tend to devalue their entire selves when they feel that they have not succeeded in these roles. Moreover, they are caught in a difficult double bind: if they adhere to the prescribed, passive stereotypic feminine role, they tend to get little out of life for themselves. When they depart from this heavily self-denying, non-assertive stance, they may get attacked - by their families who preferred them in their docile servant role - as being selfish, negligent or 'bitchy'. By feeling guilty about not living up to their sex-role expectations they create a vicious cycle: they feel more depressed, more anxious, and are more likely to perform poorly. Resultantly, they are then more likely to drink in an effort to allay their feelings of guilt and worthlessness" (Wolfe 1979, p.202-203).

Low frustration tolerance - or the inability to "stand not having the world respond the way one wants it to, when one wants" - is identified as the third "irrational" characteristic of women.

The alcoholic woman

".. is disappointed and frustrated in love relationships and when people do not meet her needs on demand; but the bottle offers warmth and pleasure and a kind of companionship *when she wants it*." (Gomberg 1974, her emphasis)

Wolfe (1979) asserts that it is the irrational conflation of wants with needs that engenders

anxiety and despair when the world and other people continue in their "normal course of acting badly". And further, that this very low tolerance for frustration stems from, on the one hand, the irrational belief that it is awful not to get what you want, or when others behave badly; and on the other hand, from the "myth of fairy tales" that tell us that if we are good and do all the right things, then some day our lives will be magically transformed. Alcohol provides a delusory and impermanent magical change⁹.

Finally, the conflation of a persons behaviour with her self *in toto* is seen by such an analysis as characteristic of alcoholic women. This engenders the anger (overt or concealed) often observed in women alcoholics and their difficulties of "impulse control". Again women are in a double bind:

"If they sit on their feelings they may be prey to depression, neurasthenia, psychosomatic complaints such as headaches or colitis, agoraphobia or panic states over undertaking household or career tasks. The response on the other extreme, sometimes by these same passively behaving women when their fuse finally blows, is belligerence or hysterical crying. The results in terms of producing the desired behaviour change, are usually quite unsatisfactory" (Wolfe 1979, p.205).

In erroneously identifying the person with their annoying or enraging behaviour, the alcoholic woman increases her anxiety and rage, rather than assertively expressing herself. However, the alcoholic woman's inability to be assertive in distinguishing the person from their behaviour, is not seen as simply a skills deficit. Rather, the inability of the alcoholic woman to express herself assertively is because of her feelings of irrational anxiety about the consequences.

This "rational emotive" response to women's alcoholic drinking rests entirely upon the liberal psychological conception of a continuity of rational individuals. The rational emotive psychologist cannot, by definition, conceive of the maintenance of alcoholic drinking through the material substance of the individuals situation. That women's (self-)worth may materially depend upon men, that women are literally and physically sanctioned for non-conformity to the feminine role, that women's material needs are not recognized and they are physically mistreated, and that women are socially required to abstain from expressing any non-feminine feelings quite simply

cannot be conceived within the psychological paradigm. Therapy designed to convince women that their beliefs have no material substance heralds a return to the explicitly patriarchal relationship between the woman who cannot realise herself and the expert doctor who can. The transposition of alcoholic drinking by the rational therapeutic relationship provides a socially validated rational continuity between the woman's external and her internal experiences. She begins to experience some consistency, and is, at last, able to rationally predict life events. The drinking woman has, therefore, achieved some equilibrium by confirming her individual implication in external events: it is her own irrationality that is at fault, rather than her material experience. And as she used to drink in order to alleviate feelings of irrationally low self-worth and anxiety to confirm and predict her guilt, the rational therapeutic relationship provides the means of continuity between external and internal control. Thus the raw irrationality and low material worth of women is consolidated.

Furthermore, the development of rationally controlled drinking in women is premised upon their free and equal ability to exercise control over their lives. Women are confined ideologically and structurally within the private domain of the home; and, as such, the key tenets of psychologically controlled drinking programmes are invalid. The suggestion that problem drinkers manage to control their drinking by avoiding the environments where they drink is untenable for women who drink where they spend most of their life - at home. The possibility of changing routines in order to move out of the habit of drinking is untenable, since the routine of housework and childcare is relatively immutable, being aligned with, for example, school hours. Thirdly, the opportunity to reduce the amounts of alcohol consumed to "healthy" measures is absent, since at home "neatly measured pub drinks" are not available. And finally, the chance to control consumption by controlling the money spent on alcohol is lacking since women often lack money and/or rely on their husband for housekeeping money. If he considers her to be unable to control the housekeeping money, then she is likely to feel

even less powerful (Mayne 1986). Psychological controlled drinking programmes, by denying the material inequity of women's experience, therefore, reaffirm women's inability to effect substantial change in their lives - and thus confirm, as a matter of material fact, their low self-worth and guilt.

CHAPTER 4:

EQUAL OPPORTUNITIES FOR WOMEN AND ALCOHOL

Cognitive psychology facilitated the re-presentation of individual will as a key aspect of general health. This twentieth century conception of will, however, was effected by social and environmental factors, rather ^{than} being individually inherent as it was in the seventeenth and eighteenth centuries. In particular, the will was now the product of a healthy socialisation, and identified in an internal locus of control: the healthy mature individual willfully determined his own actions and destiny. Gender differentiated socialisation, however, provided the means only for men to achieve an internal locus of control - or a healthy 'will'. Women's healthy cognitive development required their development of "irrational"/"unhealthy" beliefs, in particular of their external locus of control which was commensurate with their experience of determination by events and phenomena external to themselves. Such external factors effectively deny women the possibility of exercising 'will'; and

remaining so underdeveloped, women lack the self-control necessary for general health, including controlled drinking.

Insofar as women's abstinence is externally enforced through legislation and the threat of violence (chapters 1, 5, 7 & 8), women are materially prevented from developing an internal locus of control. Women are now conceived as being socially denied - through external control - the opportunity to exercise and develop a rational will, rather than as subject to intrinsically feminine qualities, characterised as abstinence. Society is, therefore, conceived as a "forced" or "unnatural" structure, lacking any "natural" authority. And such enforcement was regarded as characteristic of a particular, relatively immature society.

Hence the bond between cognitive psychology and Durkheimian sociology: both perspectives are concerned with the relationship between the individual and her social environment. And both perspectives are concerned with the efficacy of socialisation. Cognitive psychology, however,

conceives of a direct and teleological relationship; whereas the sociological conception is of a dialectical relationship:

"Individual minds, forming groups by mingling and fusing, give birth to a being, psychological if you will, but constituting a psychic reality of a new sort. It is this, then, in the nature of this collective individuality, not in that of the associated units, that we must seek the immediate and determining causes of the facts appearing therein... in a word, there is between psychology and sociology the same break in continuity as between biology and the physiochemical sciences. *Consequently, every time that a social phenomenon is directly explained by a psychological phenomenon, we may be sure that the explanation is false*" (Durkheim 1964a, p.103-4, my emphasis).

The "collective individuality" of a society is expressed in its "psychic reality" - it's characteristic "norms" (such as enforced abstinence). Socialisation, therefore, is sociologically ascertained in the individuals internalisation of the collective conscience which required the repression of individual instincts:

".. society has it's own nature, and, consequently it's requirements are different from those of our own nature as individuals: *the interests of the whole are not necessarily those of the parts*. Therefore, society cannot be formed without our being required to make perpetual and costly sacrifices" (Durkheim in Wolff p.338, his analysis)

In an unevolved asocial state humans were thought to relate to one another only in terms of the

gratification of their immediate bodily instincts; as human society evolved, however, the dialectical relationship of individuals was expressed in the social/collective conscience. In this new state of civilisation, the individual was required, in the interests of social order to accept the constraints of social morality. And, as this morality was the product of the dialectical relationship of individuals, it could not be discerned through psychology. Social morality - and hence the social order - from this sociological perspective could only be apprehended through the cumulative impact of individual activity: the rate of integration into the collective conscience. The rate of integration was believed to be quantifiable and measurable, as evidenced since the work of the nineteenth century 'moral statisticians' (chapter 2). In particular, official data on crime/deviance provided a sociological means of measuring the rate of non-integration into the social conscience.

In observing that deviation is itself a social norm - insofar as it occurs in all societies - Durkheim contended that it must functionally

contribute to the maintenance of social order. In particular, he conceived of deviance as denoting the boundaries of morality: the means of collectively rehearsing the difference between right and wrong, and thus consolidating the social order. And, as social structures vary in their means of social order, the forms of deviance characteristic of specific social structures were also shown to vary. Rates of deviance, however, irrespective of their form, indicated the relative stability of the social order. The comparative study of rates of deviance enabled the sociologist to identify the norm - the rate of deviance characteristic of a stable, healthy society. Pathologically high rates of deviance indicated that a society is terminally ill, and heralded the development of a new moral order:

"How many times, indeed [is deviance] .. only an anticipation of future morality - a step towards what will be! According to Athenian law, Socrates was a criminal, and his condemnation was no more than just. However, his crime, namely the independence of his thought, rendered a service not only to humanity, but to his country. It served to prepare a new morality and faith which the Athenians needed, since the traditions by which they lived until then were no longer in harmony with the current conditions of life" (Durkheim 1964a, p.71).

A high rate of deviance therefore, indicated the anachronistic nature of the particular social structure and of the particular means of social control; and a low crime rate indicated that the collective conscience was excessively repressive, prohibiting the organic development of society:

"There is no occasion for self-congratulation when the crime rate drops noticeably below the average level, for we may be sure certain that this apparent progress is associated with some disorder" (Durkheim 1964a p.67).

Whether rates of deviance are abnormally high or low, social pathology was indicated: the individual members of society had not entirely internalised the social conscience. This, according to Durkheim, occurred in situations of "forced" or "mechanical solidarity", when the natural qualities of individuals were neglected in the institution and maintenance of social order. Durkheim regarded this as characteristic of contemporary capitalism, where the liberal "cult of the individual" has developed individuality beyond the functional needs of a complex, differentiated society. The capitalist social conscience emphasises individual competition, and the possibility of an organic moral authority is repressed as some individuals force a division of

labour to suit their particular interests, rather than in recognition of more natural qualities. Social authority, therefore, is mechanically enforced; and consequently there is a profound tension between the (enforced) social conscience and the interests of most individuals. As individuals strive to resolve this tension, they will deviate from the social conscience.

And, insofar as individuals drink alcohol in order to relieve tension (see chapter 3), they express a disjuncture, or a strain between the functions of the social structure and the needs of individuals. High rates of alcohol consumption, therefore, indicate some degree of social pathology. This sociological perspective, therefore, conceives the individual will as dialectically related to the social conscience. And as the individual expresses her difference with the social conscience through drinking, she is expressing more than her individual determination: she is a symptom of social pathology.

Horton (1943), in an early comparative study of drinking, functionally related rates of alcohol

consumption to the mode of social subsistence. He observed that societies which were characterised by "primitive" means of production experienced food shortages; and further, that the influence of the social conscience over individual bodily needs was reduced in proportion to the danger of individual starvation. Social order, therefore, in such societies was precarious. As the individual was effected by the social structure, the more difficult her life conditions were, the more the individual experienced anxiety. Anxiety was generated, therefore, according to Horton (1943) in proportion to the "primitiveness" of the mode of subsistence of a society. As drinking was regarded as functioning physiologically to reduce the individual experience of anxiety (see chapter 3), the statistical rate of individual drinking in a society was held to indicate the level of social anxiety, and thus the degree of civilisation of that society. The rate of drunkenness in a society was thus positively related to the mode of subsistence.

This analysis was taken one step further by Field (1962), who contended that the characteristic

organisation of "primitive" societies was "personal and informal", and that it was this informality that facilitated drunkenness. As societies evolve a more formal structure, drunkenness - as the expression of informal associations - become increasingly dysfunctional. High levels of drunkenness in a society, therefore, were held to be incompatible with highly differentiated, corporate and formal social organisations. Drunkenness therefore indicated social disorder and was thus dysfunctional to a complex market economy. Hence the commodification of alcohol and the privatisation and depoliticisation of drunkenness (as social disorder) in the eighteenth and nineteenth centuries (see chapter 1).

Within the developing capitalist economy public gatherings were outlawed, the political ^h_Λ treat of such meetings neutralised as 'drunken'. The production of alcohol was industrialised, and the consumption of alcohol was thereby confined to public business transactions within the jurisdiction of licensed premises. As a corollary of the ("mechanical") abstraction of the

individual production and consumption of alcohol from its social form (drunkenness), drinking beyond the requirements of the market was increasingly subject to social sanction. The classical utilitarian conception of drunkenness as irrational and thus inhuman allowed only for the rejection of such drunken creatures from civilised society; a twentieth century Durkheimian approach, however, picks up the Victorian reformers concerns with the institution of moral values. The observation of high rates of drunkenness in an advanced society indicated that the processes for the internalisation of the social conscience (socialisation) were, to some extent, dysfunctional. Therefore the social structures involved in socialisation required reform in order that social order was maintained.

High rates of drunkenness, therefore, were held to indicate a tension between the individual and social conscience ("anomie"), which the dysfunctional individual tried to resolve by drinking. Furthermore, since the particular social form of anomic deviance was functionally related to the social structure, alcohol, drinking and

drunkenness must be ascribed with a significant social status insofar as they were used in the relief of social tension.

Following the Durkheimian analysis through, the status of alcohol was, to a greater or lesser extent, expressive of the "organic association" of the psychopharmacological qualities of alcohol with its use (functional and dysfunctional) as a social disinhibitor. This dialectical relation of the biological and social forms of alcohol and drinking provided the means for understanding drunkenness as socially dysfunctional. The chemical properties of alcohol were, therefore, seen as the necessary basis for social forms of drinking; the specific behavioural concomitants of drinking were, however, crucially dependent on social beliefs about alcohol and drinking (Robinson 1977). Consequently, the metabolic changes effected by alcohol were interpreted by the drinker in terms of her general social situation, and in turn the drinkers subjective experience of intoxication effected her already altered metabolism:

"In short, the drug experience can only be understood in terms of an ongoing dialectic

between the subjective mood of the individual and the objective psychotropic effects of the drug." (Young 1971, p37).

It is this dialectical character that makes alcohol such a 'potent' substance in both its everyday and scientific conceptions (MacAndrew & Edgerton 1969). And it is also this dialectical character that makes generalisations about the effects of alcohol necessarily false. As the individual learns 'humanity' through socialisation, so does she learn the social concomitants of drinking. And, insofar as drinking is socially associated with moral disinhibition, then the drinker will express moral disinhibition on drinking. 'Drunkenness' therefore, as a necessary concomitant of drinking alcohol is a particular social form of drinking - it is not observed in all cultures (Lemert 1951, MacAndrew & Edgerton 1969, Young 1971). And, insofar as drunkenness (as moral disinhibition) is a normal response to drinking alcohol in a society, then there must be some "fundamental connection" between drinking and the "configurations of values, ways of life and world views" (Young 1971): drinking must be functional.

Drunkenness has been observed to be functional in relieving social anxiety (Horton 1943), but dysfunctional within a differentiated, corporate and formal social organisation (Field 1962). However, drinking has been observed to be functional in complex societies insofar as they are "mechanically" or coercively differentiated (Kessel & Walton 1965). The increasing risk of social disorder in the eighteenth and nineteenth century enforcement of rational equality was resolved in the reform of the Protestant Work Ethic. The utilitarian realisation of the true nature and position of man was through hard work and painstaking application to duty; and money provided the means of expression of that true nature - the more money an individual possessed, the truer a person he was. The contradiction of irrational inequality in this ethic was resolved in the division of social sphere of the production of money from the consumption/spending of money (see chapter 1). Money became purely instrumental: it became the means to the expression of human identity and purpose rather than expressive of that humanity in itself. Thus while 'formal' social organisations retained the principles of

the Protestant Work Ethic, an informal disengagement with those values dissipated the growing risk of social disorder through the development of social structures concerned with pleasurable consumption (Berger 1963, Marcuse 1964). Leisure - *insofar as it was purchased* - provided the means for the articulation of formal production with informal consumption:

"Leisure is concerned with consumption and work with production; a keynote of our bifurcated society therefore, is that the individuals within it must constantly consume in order to keep pace with the productive capacity of the economy. They must produce in order to consume, and consume in order to produce" (Young 1971, p128).

Leisure/pleasure, therefore, was sociologically identified as functional in relieving the tensions of a society "mechanically" (ideologically) differentiated into productive and consumptive spheres. As essential 'human' status was denied in the vagaries of the formal production, it was expressed through the social organisation of leisure. And insofar as leisure was defined in pleasurable consumption and the disengagement from the values of formal production, drunkenness provided "potent" relaxation. Drunkenness therefore became functional within a "bifurcated" society: it provided "time-out" from the

"otherwise imperative demands of everyday life"
(MacAndrew & Edgerton 1969).

However, drunkenness (as leisure/pleasure) was legitimated only through the 'credit card of work':

"Alcohol, then, is a common vehicle for undermining the inhibitions built up by our socialisation into the work ethic. It is the key to an area of subterranean values which are, however, tightly interrelated and subsumed by the work ethic. It is as if the Door in the Wall merely led to an antechamber of the World of Work, a place to relax and refresh oneself before the inevitable return to 'reality'." (Young 1971, p137).

Legitimate drunkenness, therefore was regarded as a cultural solution to the enforced demands of everyday formal production, and as such it can only be understood in terms of that particular social structure. Illegitimate drunkenness described the disengagement of the drinker with the responsibilities of social world (both formal and informal). The alcoholic's (ie illegitimate drinker) dislocation from the social conscience, therefore, meant that she failed to realise the dialectical character of drunkenness: she identified the cause of her drunkenness in the substance of alcohol per se, rather than in relaxation from everyday imperatives. She

conceived herself as determined by alcohol, and consequently, her drunkenness is "out-of-control".

Women in general, however, insofar as their abstinence from formal production was enforced in the resolution of the dilemma of rational equality (chapter 1) were effectively denied the "credit card of work" which legitimated drinking and drunkenness. Furthermore, in their enforced abstinence, women were simultaneously denied legitimate pleasure/leisure and identified with men's pleasure/leisure (see chapters 1 & 2). It was women, therefore, who - *insofar as they were abstinent* - simultaneously signified leisure and provided the means of articulation of the spheres of formal production and informal consumption. Consequently women were prohibited from drunkenness not only in terms of their ("mechanical") dissociation from formal social production, but also in their simultaneous embodiment of the "glue" that holds the social structure together (Bacchi 1990) and also of men's leisure.

Drunkenness in a complex differentiated society, therefore is functional only insofar as it is integrated into formal social production. The "mechanical"/enforced bifurcation of production and consumption in such societies, however, engendered the risk of tension between social and individual values, which may be expressed in dysfunctional drunkenness; and renders women's drunkenness intrinsically dysfunctional. An "organically" integrated society, however, carried with it the promise of more healthy forms of drinking. And insofar as drunkenness (with its concomitant risk of social disorder) is a learnt ^{at} adaption to social tension, it would atrophy through either the resolution of social tension or the discovery of alternative means of expressing leisure.

Cross-cultural studies discerned a continuum of cultural attitudes effecting the perception of the health/ /pathology of different forms of drinking. Bales (1946), for example, distinguished four points in the continuum; complete abstinence; a ritual attitude towards drinking, requiring that alcohol was consumed during religious ceremonies

or festivals; thirdly, a convivial or hedonistic attitude, in which drinking became a social rather than a religious ritual; and finally, a utilitarian attitude. He contended that it was this latter form that was conducive to dysfunctional drinking, as it was a personal and self-interested form of utilitarianism rather than a social form - it was a means of forgetting individual problems rather than of developing organic social associations. Utilitarian drinking, therefore, expressed the individual's attempt to relieve the tension she experiences in a state of "mechanical solidarity", between the "forced" institution of morality and her "natural" needs. Thus the social form of utilitarian drinking was seen as pathological/ /dysfunctional, unlike other social forms of drinking and drunkenness identified by Bales (1946). And it is this form of drinking and drunkenness that is manifest in both the criminal statistics on drunken (social) disorder and the epidemiological statistics on mental disorder.

Pittman (1967) similarly found that societies characterised by "permissive" (or "convivial"

(Bales 1946)) forms of drinking were found to have generally low rates of dysfunctional drinking - with relatively low rates of arrest for drunken disorder and of psychiatric admission for alcoholism (as uncontrolled drinking). In such societies (eg France, Italy), alcohol and drinking are fully integrated throughout the social structure: the social form of drinking, therefore, is regarded as of the same significance as eating - and the "mechanical association" of alcohol with disorder (drunkenness) is replaced by a more "organic association" of alcohol with the order of everyday life. The development of civilisation through the dissolution of "mechanical associations" is, therefore, to be facilitated through the integration of social forms: the "organic" continuum between production and consumption will therefore, by this perspective, anachronise both women's enforced abstinence and the functional organisation of "time-out". The "mechanical" status of alcohol as a "superego solvent" (MacAndrew & Edgerton 1969) will organically transmogrify into everyday life.

This sociological perspective, unlike psychological perspectives, therefore saw restrictions on the availability of alcohol (as a "superego solvent" and harbinger of social disorder) as themselves increasingly dysfunctional. And the fiscal concomitant to enforced abstinence through the divorce of production and consumption - taxation in general and alcohol duties in particular - was increasingly challenged. The stagnant alcohol industry found new life as the changing social attitude to drinking, drunkenness and alcohol provided new markets - particular amongst women. The 1961 Licensing Act allowed off-licences to open during normal shopping hours with the result that grocery-store chains and supermarkets were encouraged to open drinks departments on their existing premises. And by 1977 approximately half of all Britains supermarkets had licences to sell alcohol.

Thus, as the notion of the integration of drinking throughout the social structure was incorporated into the social conscience, women, who hitherto had very low rates of alcohol consumption (Bacon

1976, Plant 1980) (which was functional to "forced" social differentiation) began to drink alongside men.

".. it has become much easier, more impersonal and more 'respectable' for women to obtain alcohol" (Shaw 1980, p.16).

Furthermore,

".. increasing attention .. is being paid to store display and promotion that is aimed at the female shopper" (Whitehead and Ferrence 1980 p.179).

While women's consumption of beer rose only marginally during that time, the consumption of white rum, gin and vodka - traditionally women's drinks - mirrored the general increase in women drinking, rising slowly during the 1960s, but increasing markedly during the first half of the 1970s. However, the market for wine virtually doubled from 1960 to 1969, and then nearly doubled again in the next five years to 1974

".. and this is precisely the sector of the drinks market where women have become the dominant purchasers and consumers" (Shaw 1980, p.11).

Furthermore, the market expanded at this time to introduce new types of alcoholic beverages, such as 'Tabboo', which did not have a traditional market like beer or wine. These new drinks, therefore were likely to be consumed by a wider

variety of social groups. Thus women's increased consumption of alcohol at this time was not due to a complete alteration in drinking habits but rather to the cumulative effect of adding new elements - different types of drink and different drinking situations - into an already existing pattern (Makela 1975).

Alongside the liberalisation of the licensing laws and the expansion of the alcohol market, the linking of the price of alcohol to inflation through the retail price index was abolished (1966/7) (Shaw 1980). And as the social integration of alcohol occurred simultaneously with the social integration of women and consequently increasing numbers of women entered traditionally "masculine" occupations (under a "forced" division of labour). As women's earning rose accordingly, so too did their opportunity to participate in traditionally "masculine" leisure activities.

"In medical school, I was very self conscious to be among all those male students... I needed relief from this feeling of not really belonging in a man's world. I began drinking... I made sure that I drank Scotch because Scotch (so the ads tell us) means acceptance and success, and I was going to be a success... *I felt I had to drink like a man*

because it meant equal rights" (Hornick 1977, p.88, my emphasis).

Between 1972 and 1977 the average weekly earnings of men rose by 104%, while women's earnings rose by 147% - in effect the average woman's wage doubled during this period (Otto 1981). Women's disposable income had increased since the 1960s, while the real price of alcohol has decreased (Shaw 1980).

Statistical research showed that the consumption of alcohol was almost exactly related to its price as a proportion of real disposable income (De Lint and Schmidt 1971, Schmidt 1977). Consequently, as the real price of alcohol falls as a proportion of disposable income, consumption will rise. The fiscal control of drunkenness diminished in relation to the re-institution of rational social equality. The assumption was that general social integration would facilitate a more "organic association" of the individual with the social conscience, thereby reducing the rate of social tension and the attendant risk of social disorder through drunkenness.

In accordance with the statistical prediction, as the real price of alcohol as a proportion of women's disposable income dropped, the proportion of women drinking rose (Shaw 1980). Therefore, not only did the "mechanical" constraints on women's economic participation diminish, so too did the constraints on women's drinking.

"...it is now acceptable for women to be seen drinking in mixed-sex company, in private and in public, although the experience of many women is that it is not as easy for them to drink *alone* in pubs as it is for men. However, compared with the attitudes held by the majority in society prior to the last war the social constraints on women drinking have eased considerably.. One example of the decrease in social constraints is the number of male-only bars that have now admitted women" (Otto 1981, p.159).

In observing these trends many researchers have observed a "convergence" of women's with men's alcohol consumption patterns: drinking was becoming less role specific and more integrated into every-day life:

"... increases in integration interact with changing roles and attributes to produce disproportionate increases in drinking among women.." (Whitehead and Ferrence 1976, p.180).

Studies of the drinking patterns of young women support this observation (Ferrence 1980, Breeze 1985). Levels of heavy drinking, however, remain very low among women generally (less than 1%

drinking more than 35 units in the measured week)
(Breeze 1985)¹.

"In summary, heavy drinking .. is consistently and substantially greater among men than among women even when sex differences in body weight and composition are controlled. Available data provide no evidence to support convergence and one set of data suggests the possibility of divergence" (Ferrance 1980, p.89).

Insofar as heavy drinking is dysfunctional, therefore, it may be argued that the integration of alcohol into everyday life through making it more accessible to women, has facilitated the development of a new cultural form of functional drinking, modelled by women (Allen 1985), and in particular middle class women (Dight 1976, Otto 1980, Ferrance 1980, Breeze 1985).

Thus the argument that the structural strain caused by the construction of alcohol a "forbidden fruit" (Whitehead & Ferrance 1976) was resolved through the rational 'normalisation' of alcohol. The general cultural movement towards 'equality' provided the social framework for the abolition of the ("mechanical") identification of some social goods as "demons", as "demerit commodities" (Room 1983). The new social conscience of equal

opportunities facilitated a new appreciation of the radical equality of the market.

Simultaneous with the normalisation of alcohol, however, epidemiologists began to notice that general population rates of alcohol consumption were strongly correlated with the development of alcohol-related pathologies - such as cirrhosis of the liver, pancreatitis, carcinoma of the oesophagus and alcoholic psychosis itself. The medical failure to provide any satisfactory definition of individually 'pathological' drinking, nevertheless hindered the identification of socially pathological rates of alcohol consumption. It remained impossible to identify the rate at which the individual development of organic illness in relation to alcohol consumption began to threaten the social structure. The solution was found in a simple Durkheimian approach: if rates of 'normal' alcohol consumption could be defined, then 'abnormal', or pathological, amounts, logically would also be defined. Furthermore, if the health of the individual and society were dialectically related, the identification of 'dangerous' rates of

consumption would effect the collective conscience, and reduce the threat. Thus the solution to the problem of pathological drinking at an individual and a social level was sought at the moral level of the social conscience.

In 1952, the World Health Organisation defined alcoholism as

".. any form of drinking which in its extent goes beyond the traditional and customary 'dietary' use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behaviour and irrespective also of the extent to which such etiological factors are dependent upon hereditary, constitution or acquired physiopathological and metabolic influences."

The key criterion of the 'disease' here being *deviance* from 'normal' alcoholic consumption. And, while epidemiologists observed that average (per capita) consumption of alcohol in most Western societies had substantially increased since the Second World War, most 'normal' people who drink alcohol were not likely to experience problems or "damage" due to their drinking. Those individuals who did drink amounts likely to cause problems account for less than 10% of the general population, and not all of this group will

necessarily experience alcohol-related problems (Popham and Schmidt 1958).

Ledermann, in 1956, observed that a steady statistical pattern would always, in all circumstances, describe the distribution of drinking frequencies among populations - and consequently predict the rate of alcohol-related problems. He hypothesized that the natural logarithms of consumption, rather than the raw consumption data, were normally distributed. Consequently, not only was the proportion of individuals who experienced alcohol-related problems positively correlated with average levels of consumption in a society, but also that increases in per capita consumption were shown to produce *exponential* increases in rates of alcohol-related-problems. Thus a given increase in average consumption will produce an increase in "hazardous drinking" that is, on average, proportional to the square of the increase in per capita consumption: consequently even moderate increases in the average consumption of moderate drinkers can lead to a significant increase in general alcohol-related problems.

The 'Ledermann hypothesis' described the relationship between the normalisation of alcohol (for example in countries such as France and Italy), which entailed high rates of per capita consumption, and high rates of alcohol-related pathology, in particular cirrhosis of the liver. And vice versa, the relationship between low rates of per capita consumption of alcohol in countries such as Norway and Finland, and low rates of death due to cirrhosis of the liver (De Lint and Schmidt 1971). Thus the higher the per capita consumption of any social group, the greater the proportion of that group would be expected to develop alcohol-related problems.

"If we look at .. geographical comparisons .. international and regional differences in mortality rates [from cirrhosis of the liver] are very closely associated with differences in the apparent per capita consumption of alcoholic beverages...

[This is] confirmed by a long series of empirical investigations involving many regional and temporal comparisons. The picture that emerges is consistent: the rate of death from cirrhosis rises and falls with the level of consumption in the general population" (Schmidt 1977, p.24-27).

The 'Ledermann hypothesis' implied, therefore, that the biological/psychological focus on the diseased individual was no more than a medical

fetish: the alcoholic individual was an expression of a "mechanical" social structure, where the interests of the "egoistic" few "forced" the identification of the social whole with its individual constituents, to the detriment of the wider collectively. The new epidemiological appreciation of alcohol-related-harm recognized that the dialectical relation of the individual with the collective conscience engendered a social morality which transcended its individual expression: the magnitude of alcohol-related-problems transcended individually identified 'alcoholics'. The stereotypical alcoholic, therefore, was only the tip of the iceberg, and increasing numbers of researchers began to work on the development and correlates of particular problems *related to drinking* rather than assuming an underlying individual pathology or maladaptation was the source of all problems.

Research began to indicate that the alcohol consumption patterns conducive to the development of specifically quantifiable medical conditions such as cirrhosis of the liver also resulted in a "very wide range of other health and socio-

economic problems". Schmidt (1977) noted that Ledermann (1956) observed that the individuals who were asked about their drinking patterns in surveys tended to explain their consumption in terms of the consumption of others. From this observation, drinking was conceived as an "other-oriented behaviour", so much so, in fact that Schmidt (1977) suggested that it was a form of "social contagion". It was this social/moral contagion that was held responsible for the interrelatedness of the frequencies with which certain consumption levels occur. In short, the consumption of alcohol, being "socially contagious", has a "snowball effect".

Insofar as harmful drinking was conceived as a form of moral contagion, the integration of drinking into everyday life therefore was seen to be fallacious. Rather than viewing the social constraints on drinking as characteristic of enforced social differentiation and the related fetishisation of alcohol, such constraints were now evidenced by the epidemiological data on alcohol related harm as, in fact, "organic" - healthy. Individual 'freedom' to consume alcohol,

rather than being healthily "organic", was seen therefore as the product of the "forced" notion of the equality of alcohol with all other commodities expressed in the normalisation of alcohol. The capitalist market was now seen more critically as "forcing" a "permissive" cultural attitude to alcohol, drinking and drunkenness. And objective social science now evidenced this "forced" cultural 'freedom' as immensely socially harmful: the rate of alcohol-related-harm was not *equally* related to the rate of alcohol consumption, but *exponentially* related to alcohol consumption.

Consequently, attention to the statistics on per capita consumption and the development of alcohol-related problems facilitated the development of a new 'temperance morality'. There was new concern about the social "atavatism" expressed through a social structure that actively encouraged the development of alcohol-related problems, thereby draining social and economic resources (see chapter 1). The new worry about disease was not conceived in individual terms, but rather in terms of the social magnitude of alcohol-related disease:

".. distinctions between the concept of alcoholism as a disease and the concept of problems-related-to-drinking are not mere quibbles. If an alcoholism-as-a-disease model is emphasised, public policy tends to be oriented around the *individual* as the locus of the disease; and alcoholism research and treatment accordingly take on a clinical and pathological emphasis. If instead the 'problems' approach is emphasised, there are fewer conceptual barriers to viewing the drinking problems as associated with disjunctions in the interactions between the individual and his environment - with considerably different implications for research and remedial measures... .. findings suggest that the alcoholism paradigm does not fit well with the life experiences of the general population... To project too readily the [alcoholism] paradigm .. on the [larger community] is faulty, we have argues, and misses much that is important, and conceptualises it ineptly" (Clark and Cahalan 1977, p.183-184).

Thus 'problem drinking' (as abnormally high levels of consumption) can be identified as the responsibility of a wide range of agencies and institutions, from family and peer groups to government institutions.

This new 'comprehensive' conception of problem drinking had major implications for social policy. In 1978 the Central Policy Review Staff concluded from their review of alcohol policy in the Britain²

"... that the trends in (alcohol) misuse justify government concern. Without government initiatives and a better concerted

set of policies these trends are likely to continue."

But, in considering the Royal College of Psychiatrists (1979) recommendation that the level of per capita consumption of alcohol should not be allowed to increase beyond its current level, and further, that it should be gradually brought back to an agreed-upon lower level, the Review concluded that

"We do not think that it is realistic to propose a policy that takes no notice of [the broader context of economic and social forces]. For this reason we cannot advocate the early adoption of the proposal from the Royal College of Psychiatrists. But we are convinced that, from the point of view of alcohol policies alone, it is a proper objective" (CPRS p.17).

Thus the CPRS asserted the difference between an alcohol policy concerned exclusively with alcohol, and one which placed alcohol within the broader context of the balance of social and economic forces at the level of the state.

"The government is directly or indirectly involved in nearly every aspect of the production and consumption of alcohol. It has an interest in the well-being of the alcohol industry, in the trade in alcohol, and in the employment generated; it receives a large amount of tax revenue from the sale of alcohol; it imposes certain restrictions on consumption; and it bears the cost of the consequences of alcohol misuse. There are thus a great number of alcohol policies" (CPRS p.4).

Hence the premiss that the state's role was to

".. facilitate the operation of the economy as a whole" (CPRS, p.70).

The Brewers Society estimated that at the time of the Review, the alcohol industry provided more than £2200 million in farmers incomes; used about half of the total number of bottles produced in Britain; employed approximately three quarters of a million people in production, distribution and retail; contributed almost £500 million to the balance of trade; and provided the government with over 5% of its total annual income in excise duty and VAT on drinks.

However, I think that it would be too simplistic to suppose a 'conspiracy' of the government and the alcohol industry in the development of alcohol policies. And, in fact, the CPRS themselves noted that

"The state also has fiscal and electoral considerations and fields these considerations within the general framework of commitment to industry generally .. as distinct from any particular section of capital"

Nonetheless, the CPRS did support the Ledermann hypothesis that the rate of alcohol-related-harm is directly related to the rate of per capita alcohol consumption, and forwarded a modified

version of the Royal College of Psychiatrists proposal: that consumption is held at it's present level *but not that it should be reduced*. To this end, the CPRS recommended the development of a coordinated government strategy to reduce the level of alcohol related harm. The first priority was to prevent per capita consumption rising by the linking of the price of alcohol to inflation by raising excise duties in line with inflation. And to back up the market discipline of real price, the CPRS also recommended the enforcement of legislation on under age and drink-driving and the development of a broad-based health education campaign.

The CPRS Report was not issued, and the detail of their recommendations was not made public due to conflicting priorities within the government (Alcohol Concern 1987a). Instead, the DHSS (1982) published the Drinking Sensibly report, which stated that

".. taking account of the economic considerations and bearing in mind the practical difficulties involved, the Government cannot accept recommendations that have been made for the systematic use of tax rates as a means of regulating consumption."

Thus the CPRS concerns that per capita alcohol consumption should be held at its 1979 level through a combination of *fiscal and* health educational policies were repudiated in favour of a health education policy alone.

The British government, therefore, favoured a "weak" or "common-sense" (Tuck 1980) conception of the distribution of consumption model of alcohol problems. They retained the classical mechanical model of society based on the tautological reasoning that an individual cannot develop alcohol problems if she does not consume alcohol. The "stronger" conception of the distribution of consumption model of alcohol problems advocated by the Royal College of Psychiatrists (1979) was rejected, and with it the possibility of an appreciation of the dialectic of the individual and society, wherein the social was greater than the sum of its parts. Thus the Ledermman hypothesis, which indicated that if an individual was damaged through her participation in society, for example by drinking, the dialectic will ensure that the damage to society is not

commensurate with, but exponentially related to individual damage.

Consequently, insofar as the individual taste for alcohol is encouraged through the "forced" discipline of the market, not only will the individual be damaged but the potential for the development of "organic" social differentiation will be retarded. And as epidemiological research on alcohol-related problems advanced, the Durkheimian sociologist was provided not only with the means to refute the principle of the social incorporation and normalisation of alcohol, but also with the means to explicate the "inorganic" nature of the contemporary belief in 'equality'. Insofar as the rate of alcohol-related-harm was not distributed equally throughout the social structure, forced cultural 'freedom' and 'equality' could be exposed not only as fallacious, but as regressively "inorganic".

The influence of the notion that the integration of alcohol throughout the social structure prevented the development of alcohol problems paved the way to the liberalisation of the

licensing laws in the 1960s. This provided the market opportunity for women to purchase alcohol. And the (ostensible) relaxation of gender status and growth of equal opportunities for women in the labour market provided women with the means to take up the opportunity to buy alcohol. The rate of women's per capita consumption of alcohol increased. And, accordingly, the rate of women experiencing alcohol-related-problems increased. This is evidenced in the decreasing ratio of women's to men's alcohol-related mortality: the ratio of men to women certified dead as due to alcoholism in Britain dropped from 2.1 men to 1 woman in 1973, to 1.5 men to every 1 woman in 1975 (Shaw 1980)². And the data generally show that the incidence of cirrhosis of the liver and alcohol psychosis among women is increasing (Wilkinson 1980, Breeze 1985).

Given that women have a higher proportion of body fat and thus a lower proportion of body water than men, the same amount of alcohol in a woman's body will be less diluted than in a man's body (chapter 3). And since the physiological consequences of alcohol consumption depend upon the concentration

of alcohol in the blood and bodily tissues (Ferrence 1980), it is likely that as women consume more alcohol they will experience an increased incidence of alcohol-related morbidity⁴. And accordingly, the epidemiological data increasingly indicate that the incidence of alcohol-related-morbidity among women is disproportionate to their per capita consumption. Women are statistically more vulnerable to cirrhosis of the liver and anaemia in relation to their consumption of alcohol; alcoholic dementia is about three times more prevalent among women than men alcoholics (and is apparent in women after a shorter and smaller exposure to alcohol); and Wernicke-Korsakoff Syndrome, which is frequently associated with but distinct from alcoholic dementia is more common among women than men alcoholics (Wilkinson 1980)⁵. Therefore, as women's disposable income increases and as gender roles 'converge' their alcohol consumption will rise (De Lint and Schmidt 1971, Schmidt 1977); but the epidemiological data predict, however, that women's experience of alcohol-related-harm will be incommensurate with their increasing consumption of alcohol. Women's increasing risk of biological

harm^a may be seen by this perspective as evidence of the "forced" nature of their equality.

Functionalist sociology, therefore, in focusing upon the rates of deviance in society as a means of measuring its general well-being developed a dialectical understanding of the relationship of the individual to society. Whilst some degree of deviation was regarded as healthy and functional insofar as it reinforced social consensus and facilitated progress from anachronistic social structures, abnormally/unusually high or low rates of deviance, by this analysis, were taken as indicative of social (rather than individual) pathology. In particular, pathological rates of deviance were indicative of the non-articulation of the individual with the social conscience, expressed in individual stress (anomie) and pointing to a breakdown of the social structure. The individual consumption of alcohol was seen as functional in temporarily resolving stress; and a high rate of drunkenness in society was regarded as functional in facilitating progress from an anachronistic social structure. Drunkenness, by

this analysis, expresses social disorder (chapter 1) rather than individual disorder.

Mid-twentieth century cross cultural studies of alcohol, drinking and drunkenness, informed by this functionalist analysis, suggested that the resolution to the problems of social disorder indicated by high rates of drunkenness was to integrate alcohol into everyday life; and further, to re-integrate production with consumption through the development of equal opportunities policies which enabled women to participate on an equal basis with men in productive activities. This would enable women to participate on an equal basis with men in leisure activities, such as drinking. The 'normalisation' of both alcohol as a commodity equal with other commodities, and women as equal with men was facilitated primarily through fiscal policies which increased wages generally whilst reducing the tax on alcohol. And as the legislative enforcement of abstinence was reduced the rate of social disorder/drunkenness decreased. The social structure maintained its stability.

However, concomitant with the reduction of social disorder expressed in drunkenness, the widespread availability of alcohol led to an increase in alcohol-related-harm. The epidemiological methodology of the functionalist sociologists provided the means to discern the exponential rise in alcohol-related-harm in relation to the rise in per capita consumption of alcohol. Through this statistical relationship, alcohol was functionally related to a wide array of social problems and the early twentieth century interest in health/temperance education re-emerged. Increasingly, the epidemiological evidence pointed to women's greater morbidity and mortality through alcohol consumption; and the incommensurate degree of damage done to women through their consumption of alcohol led to their increasing paternalistic surveillance. Concern grew that the "enforcement" of women's equality was damaging to women individually, and in the dialectical relationship of individuals to society, the equalising of opportunities was dysfunctional to society. Health educators and the social services were increasingly targeted to inabstinent women, who

came again to embody the threat to social stability.

CHAPTER 5:

FEMININITY, DEPENDENCY AND DRUNKENNESS

The notion of the continuity of alcohol with any other market commodity paralleled the development of equal opportunities initiatives for women. The liberal/psychological notion of an equal continuum (chapter 4) denied both the persistence of drunken disorder and also of the material inequality of women in terms of women's experience of alcohol-related-harm and also in wider terms of their status in society. As such, psychological perspectives have reflected the incorporation of the cultural form of alcohol into productive (public) intercourse (chapter 1); and also the incorporation of women into public (productive) intercourse through equal opportunities legislation. Through such incorporation the political impact of both drunkenness and women's activity have been domesticated. However, the appeal of the notion of equality is belied by the real threat of physical harm: women's inabstinence incurred not only the threat of physical attack and paternalistic surveillance (chapters 1 & 2),

but also, in terms of alcohol consumption, a disproportionate risk of bodily illness (chapter 4). The growing influence of epidemiological perspectives provided a positive basis for the development of paternalistic *alcohol* (as opposed to 'social') policies, aimed at containing and controlling the social consumption of alcohol. And, in intellectual partnership with cognitive approaches to alcohol and alcohol-related-problems, general health education superseded individual behaviourist intervention in harmful drinking: the populace was motivated to join in utilitarian partnership with the epidemiologists and psychologists in the battle against the demon drink. Drunkenness (as the rate of alcohol-related-problems rather than social/political disorder) became a symptom of erroneous intervention into market forces - and drunks, rather than being conceived as the victims of their bodies, were individually transmogrified into the victims of society. Women, however, remained the victims of both their bodies and of society.

Thus, the unfolding of twentieth century understandings of alcohol, drinking and drunkenness described a psychologised dialectic of structural determination: functionalist social psychological perspectives on drinking and drunkenness in the 1960s and 1970s simply consolidated the recruitment of drunks and deviants in their own containment (chapter 3). And the organic premises of such sociological perspectives crystalised the psychoanalytic and psychological determination of the gendered bifurcation of society.

The prevalent Durkheimian approach in the sociological analysis of social problems provided the means for strengthening psychologised conceptions of society in the inheritance of Durkheim's focus on the moral conditions necessary for social order. Durkheim's analysis of contemporary capitalism as an historical stage where the liberalist "cult of the individual" developed beyond the functional needs of a differentiated society, explained contemporary social problems - such as drinking and drunkenness - in individual/psychological terms. In the

evolution of capitalism, individuals began to perceive their interests as greater than the interests of the social collectivity: the competition of all individuals to realise their specific wants meant that the 'natural' talents of individuals were neglected and organic moral authority was repressed as some powerfully egoistic individuals 'forced' a division of labour to suit their interests. In the resulting 'unnaturally' determined social structure, social order became an ever-present social problem since there was a profound tension between the (enforced) social conscience and most individuals interests. Dissensus, therefore, or conflict, by this analysis, was regarded as dysfunctional, and explained in terms of individual egoism (chapter 4).

Durkheim envisaged the evolution of "spontaneous" occupational associations as irrational, egoistic customs such as the inheritance of private property were abolished. Again this was conceived in psychologised, individualistic terms:

"Whereas [mechanical solidarity] implies that individuals resemble each other, [organic solidarity] presumes their difference. The first is possible only in so far as the

individual personality is absorbed into the collective personality: the second is possible only if each one has a sphere of action which is peculiar to him i.e. a personality. It is necessary, then, that the collective conscience leave open a part of the individual conscience in order that special functions may be established there, functions which it cannot regulate" (Durkheim 1964b p.131).

Within a structure of organic solidarity, therefore, difference would be expressed through personality. And such personality differences would, of necessity, express natural differences - or inequalities. Thus the 'spontaneous' division of labour would herald a society structured

".. in such a way that social inequalities exactly express natural inequalities" (Durkheim 1964b p.377).

Durkheim therefore asserted that the notion of a social and individual continuum was characteristic of mechanical, enforced solidarity, and that as civilisation progressed, a functional bio-cultural¹ dialectic would provide the means for natural consensual social differentiation.

Durkheim rejected the radical utilitarian conception of rational equality, as did Mill (chapter 1), in favour of a 'naturally' differentiated society. Furthermore, he ascribed to the positive scientific vision of a natural/biologistic meritocracy that he regarded

as characteristic of an organic social structure. He contended that such an advanced form of civilisation would "exalt the soul", releasing it from its dependency upon the body:

".. civilisation can be fixed in the organism only through the most general foundations on which it rests. The more elevated it is, the more, consequently, it is free of the body. It becomes less and less an organic thing, more and more a social thing" (Durkheim, 1964b, p.321).

Thus Durkheim's conception of the collective conscience expressed the dialectic of *individual biology* and society: he envisaged the evolution of a natural, organic morality through *the perfect correspondence of biological qualities with social statuses*:

"Woman would not be officially excluded from certain functions and relegated to other. She could choose more freely, but as her choice would be determined by her aptitudes it would generally bear on the same sort of occupations. It would be perceptibly uniform, though not obligatory" (Durkheim 1952, p.385n).

Thus, insofar as a civilised society is characterised by a 'natural', consensual social structure, the freer it is of mechanical, bodily demands, and the freer it is of anomie, of tension between the moral stance of the individual and of society. Thus levels of anomie indicate the degree of civilisation of any particular society.

Durkheim thus asserted that society was structured by social forms (beliefs, customs, ideologies etc), and consequently that the mainspring of social action was social, rather than economic. Social problems, therefore, were traced to the nature of the social conscience. Within the contemporary state of mechanical solidarity characterised by the anomic pursuit of individual rather than social ends, the social conscience is seen as being 'forced' rather than 'organic' and consensual. It is this enforcement that causes a tension between the individual and social conscience, which in turn causes the social problems of disorder. *It would be erroneous, therefore according to this analysis, to site reform at the level only of the economic, since the economic organisation of society is constructed in terms of the moral nature of society.* Hence the explanation of the exacerbation of the social problems of drinking and drunkenness in the 1950s and 1960s in terms of intervention focused primarily at the level of the economic. The denial of 'natural' differences between women and men by permissive economic legislation (based

on the notion of a continuum) was thus seen as rendering women more vulnerable to physical damage (chapter 4). Effective intervention into social disorder must, therefore (for Durkheim) recognize the bio-cultural dialectic. Furthermore, this dialectic (statistically expressed in the Ledermann hypothesis (chapter 4)) affirmed women's 'natural' abstinence: the 'enforced' extension of equal drinking opportunities to women was exposed as contrary to women's 'natural' aptitudes. *Effective intervention, then, by this analysis, requires the development of an organic (and therefore consensual) social conscience, recognizing natural (biological) differentiation.* Economic interventions must be secondary (in their causal efficacy) to social/moral interventions. Health educational, as well as fiscal policies, were therefore necessary in order to deal effectively with the social problems of drinking and drunkenness.

A Durkheimian perspective, therefore, has effected sociological approaches to drinking and drunkenness: the social/moral form of drinking was analysed as functional in resolving social strain

engendered through enforced social differentiation (chapter 4). The liberalisation of economic controls on drinking were demonstrably 'unnatural' as they have resulted in an exponential increase in the rate of alcohol-related problems, particularly among women (chapter 4). And the solution to these problems was, therefore, in the re-introduction of economic controls which were informed by an organic and consensual appreciation of 'natural' differences; and also in the revitalisation of the collective conscience catalysed by health educational campaigns (chapter 4). As women are conceived as naturally less free of their bodily constraints (as evidenced in their greater experience of harm through drinking), economic and moral controls on drinking should encourage women's abstinence. And through these controls, social health and organic social order will be facilitated: twentieth century sociology returns to Victorian social values.

In focusing on the moral conditions necessary for social order, Durkheim², and functionalist sociologists in general found it hard to

"resist the conclusion that *anything* that produced consensus, restraint and order was

intrinsically moral... Order, in short, becomes the fundamental basis in terms of which the moral itself is conceived."
(Gouldner 1971, p252).

Dissensus - or conflict - was, by this analysis, both synonymous with an atavistic social structure, and devoid of any political impact. High rates of alcohol-related problems, insofar as they expressed structural tension or strain, therefore, were regarded as socially pathological, and in terms of the bio-cultural dialectic, individually immoral/anomic. And the possibility of the individual determination and control of drunkenness became conceptually impossible: the *conscious individual choice* to drink in a 'harmful' manner became literally inconceivable as measures of 'harm' became objective social facts. *The fact of harm was a bio-cultural fact: conscious human intervention in either the cause or the resolution of this fact was impossible*, and the issue of the social control of drinking and drunkenness became simply a matter of utilitarian (chapter 4) factual necessity. Drunks and incontinent women were thus functionally conceived as factually immoral: their mechanical persistence in drinking was positive proof that they were enthralled to their bodies - objectively inferior

to their sober and abstinent contemporaries. The possibility of the pre-modern conception of drunkenness as political - as expressive of conflict - was impossible as drinking was functionally related (determined) to the social order: and the possibility of the subjective nature of harm (harmful to whom, by whom) was effectively prohibited through the establishment of 'disease' as a metaphor for the state of society, and the institution of medicine as the key means of resolving social ills. Functionalist (Durkheimian) sociology, in resting upon the bio-cultural dialectic, embalmed the concept of disease in defining social problems.

Contemporary understandings of inabstinence/
/drunkenness which rest upon a notion of a bio-cultural dialectic make use of disease metaphors to specify an ideal of social well-being "analogised to physical health" (Sontag 1978).

"Order is the oldest concern of political philosophy, and if it is plausible to compare the polis to an organism, then it is plausible to compare civil disorder to an illness. The classical formulations which analogise a political disorder to an illness - from Plato to say Hobbes - presuppose the classical medical (and political) idea of balance. Illness comes from imbalance. Treatment is aimed at restoring the right

balance - in political terms, the right hierarchy. The prognosis is always, in principle, optimistic. Society, by definition, never catches a fatal disease." (Sontag 1978, p76)

Functional understandings of drunkenness - and deviance in general - tend to work from Durkheimian premises of 'strain' or 'tension' between the individual and society. From this, disease metaphors are used to judge society as 'repressing' the individual: the pathological repression of individuals is conceived, therefore as an expression of an imbalance between forced and natural/organic social structures.

"Early capitalism assumed the necessity of regulated spending, saving, accounting, discipline - an economy that depends on the rational limitation of desire... Advanced capitalism requires expansion, speculation, the creation of new needs .. buying on credit, morbidity - an economy that depends on the irrational indulgence of desire." (Sontag 1978, p62-63).

The economic structure of society in the eighteenth and nineteenth centuries, therefore, was related to a moral climate of capital abstinence. This, in turn was analogised to individual abstinence from expression/pleasure beyond the realms of production: individuals were conceived as deriving moral satisfaction only through the accumulation of capital - as the fruit of human labour: satisfaction achieved by any

means beyond the market was immediately morally suspect (chapters 1 & 4). Evolutionary notions provided the means for conceiving such immoral gratification as an expression a weakened constitution, leading to disease, and ultimately death. The cholera and syphilis epidemics of the mid-nineteenth century, however, brought disease and death to many men whose morality was conceived in their possession of capital. And the idea that material wealth expressed moral wealth and provided protection from disease expired: neither cholera nor syphilis were respecters of social class. Such diseases, therefore, mimicked the social movement to political equality; and the rich fears of inherent dangers in the pursuit of rational equality coalesced in the experience of disease.

Chadwick's (1842) investigation into the causes of the cholera epidemics lead to development of the germ theory of disease. In contrast to the earlier notion of disease as the expression of immorality - of inabstinence - this new scientific theory identified disease with material dirt: "filth". Dirt provided the means of production of germs,

but disease, however, was caused by the *consumption* of germs. *Disease was thus identified in the social institutions of consumption.* The social institutions of consumption, therefore, became a matter of wide social concern and intervention (chapter 1). Hygienic efforts were primarily focused on the home, and *the medium for the transmission of germs was identified in women as the embodiment of 'home' and of (men's) consumption* (chapters 1 & 4). Disease became a metaphor for the general demise of social order based on rationalist notions of the balance/continuity of production and consumption. Social freedom from disease - and thus general social welfare - was no longer attainable simply through the accumulation of capital, but through the control of the institutions and processes of consumption - embodied in women.

Late twentieth century sociology, insofar as it rests upon an organic/functionalist conception of society, returned to these nineteenth century understandings of disease and the social malaise in the transmogrification of social dis-order as individual dis-ease. It was this modern conception

of health/disease that allowed for the late twentieth century revalorisation of women's 'natural' abstinence: the rhetoric of women's absolute equality was replaced by that of women's different but equal worth. The positive location of disease in the realms of consumption and the functional definition of women as the means of human expression through consumption (chapters 1 & 4) meant that *women embodied the state of health/disease of society*. The modern transmogrification of health/disease from moral categories to positively objective categories made the possibility that the control of women in the interests *only* of men was inconceivable: contemporary women's abstinence was conceived as in the interests of *all* (men and women) insofar as it functionally ensured the healthy expression of human society through leisured consumption.

Hence the medical institution of the Millian conception of dual spheres - one relatively free of welfare intervention, the other (more concerned with the bodily processes of reproduction and consumption) controlled and defined through welfare intervention (chapter 1). And again, both

spheres were related through abstinence: the 'free' sphere effected by fiscal policies, which, in turn, effected the nature and extent of welfare provision in the bodily enthralled sphere. Organic social metaphors, therefore, eliminated the prospect of (gender) conflict through the functional articulation of parts of the social totality. The identification of women with disease through consumption was, therefore, functionally related to production and health through institutional welfare interventions. And, further, the (social and individual) repression of disease through the consensual repression of women provided the means for the healthy expression of society. Thus the objective control of social disease through the repression of conflict came to express the essential nature of civilised society. And thus the functional argument that to see the relation between repression and expression, and between consumption and production as one of subjective conflict is to mistake a part of the social totality for the whole - to neglect the essential nature of society.

The nineteenth century movement towards reformist intervention in general social health and welfare was analogised in the movement away from the expression of essential human nature through the accumulation of capital. The germ theory of disease provided the means for the identification of human (individual and social) health in the sphere of (feminine) consumption: hygienic domestic and personal circumstances - rather than the private accumulation of capital - ensured protection from disease. The essence of civilised society therefore, was institutionally expressed in welfare intervention as the means to ensure hygienic consumption; and essential human nature achieved civilised expression in hygienic (controlled) consumption.

Civilised human individuality reached its purist expression in the modern conception of disease as the ultimate locus of consumption. Where cholera and syphilis epitomised the rational continuity of production with consumption, masculinity and femininity, drunkenness and sobriety (chapters 1, 3, & 4), tuberculosis epitomised the 'civilised' separation of the 'essential human self'

(expressed through consumption) from crude physical demands (production).

"TB ... was a way of describing sensuality and promoting the claims of passion in a way describing repression and advertising the claims of repression, the disease inducing both a 'numbness of spirit' .. and a suffusion of higher feelings. Above all, it was a way of affirming the value of being more conscious, more complex psychologically. Health became banal, even vulgar." (Sontag 1978, p25).

The functional bifurcation of society into the spheres of production and consumption was individually conceived in the relation of mind (will) with body. *Health/disease was conceived as the modern product of the individual will:*

"Disease is the ill speaking through the body, a language for dramatising the mental: a form of self-expression." (Sontag, 1978, p.44).

The nineteenth century spread of TB (at an individual level), therefore, analogised the social development of consumption as the location of the expression of humanity. And disease, whether of the individual or of society, was explained in terms of the imbalance of production and consumption - repression and expression - to be cured by true and essential human will. Bodily expansiveness (production), with its attendant risk of physical infection (for example through

multiple sexual contacts), was increasingly regarded as diseased; and the epitome of humanity shifted to the hygienic repression of physical productivity (for example in women's marital monogamy). The early capitalist anxiety about the excessive expenditure of energy and the association of immoral inabstinence with disease gave way to a more modern anxiety over the "destructive over-production and increasing bureaucratic restraints on the individual" (Sontag 1978).

The romantic nineteenth century motif of tuberculosis heralded the contemporary expression of health through consumptive indulgence rather than in repression. Pre-modern conceptions of health in terms of balance achieved through the "limitation of expansiveness" were replaced, as the nineteenth century gave way to the twentieth century, by the modern notion that health is ensured through the expression of "expansiveness". *The location of health shifted from abstinence to inabstinence of will and desire.* Thus the valorisation of (hygienically controlled) consumption as the location of the individual and

social health: 'pre-modern' conceptions of health in terms of balance achieved through the "limitation of expansiveness" (through abstinence) were replaced by the modern notion that the expression of excessive feelings is positive:

"He who desires but acts not, breeds pestilence." (Blake, Proverbs of Hell, quoted in Sontag 1978)

Economic structures, therefore were translated into individual structures, and economic processes were to be apprehended through the individual expression of health or disease. The economy was reduced to the self-expression of individuals. Health was now conceived as expressive rather than repressive, and provided the analogue for the necessary inabstinence of late capitalist production. And further, the denial of satisfaction of desire through consumption was conceived as the denial of individuality: in the intensive and over-productive climate of the mid-late twentieth century, the repression of consuming energy was regarded as pathological, a denial of the essential human self, and manifest in disease (Sontag 1978).

As the twentieth century progressed, the optimistic tenor of the disease metaphor gave way to a more pessimistic "melodramatic". Early modern conceptions of illness as imbalance - of individual and society, of body and mind - allowed for the possibility of cure through the restoration of healthy balance (hierarchy).

However,

"[t]he modern idea of revolution, based on an estimate of the unremitting bleakness of the existing political situation, shattered the old, optimistic use of disease metaphors." (Sontag 1978, p80)

Disease was now conceived as death, the only treatment being attack and eradication, rather than 'management' or 'treatment':

"The melodramatics of the disease metaphor in modern political discourse assume a punitive notion: of the disease as .. a sign of evil, something to be punished." (Sontag 1978, p82).

The bio-cultural dialectic and the use of the organic social metaphor by both the left and the right throughout the twentieth century provided the basis for the development of social intervention in dis-ease. In particular, the bifurcation of society into structures of production and structures of consumption allowed for the institution of welfare intervention in

disease (chapter 1), which was increasingly located in consumption: individual/social disease was conceived as due to the repression of (male) expression through consumption. Furthermore, abstinence in production, which was established through fiscal policies³, provided the means of intervention in consumptive dis-ease⁴.

The National Health Service was established in 1948 on the basis of the social consensus that disease was primarily due to social structural tensions - such as unemployment and poverty - and that as society evolved a more organic/
/spontaneous/democratic structure ill health would reduce sharply (Durkheim). And furthermore, that the principle of free health care on demand to all, embedded in the National Health Service, would itself facilitate a more organic/democratic society as individuals were relieved of their bodily disabilities. The assumption was that the demand for free health would initially expand rapidly, but that as the health of society increased this demand and the concomitant requirement for state expenditure would reduce.

However, the establishment of health and welfare services based on the modern conception of disease as the function of the repression of essential human expression, however, is not gender-neutral. Social and individual health was conceived in a specifically gendered form. *Simultaneous with the modern conception of (patriarchal) health through the active gratification of (men's) "passions", women were increasingly subject to supervision/ /control of the expression of their will/desire/ /enjoyment* (Hey 1986). Women's healthy sexuality, in particular, was not conceived in terms of activity and desire, but in terms of consumption. Furthermore, men's healthy realisation of their 'essential humanity' - insofar as it was actively expressive - required their consumption of women's sexuality.

".. women are used to maintain solidarity and ambivalent rivalry between men: jokes [are] used to stereotype women as contemptible and as sex objects to be controlled, prestige [is] related to an ability to control one's wife." (Brake 1980, p150).

Women's expression of desire/enjoyment, alternatively, was equated with sexually improper conduct which rendered such women beneath contempt:

"Their lack of self-restraint was viewed as far more threatening and morally offensive than the equivalent male action." (Hey 1986, p33).

And in the institution of health as essential masculine expression and the concomitant establishment of disease as masculine death, women's active expression (insofar as it inhibited patriarchy) was conceived as not only "morally offensive", but as diseased: the harbinger of death. Health thus became a masculine prerogative: women being sick insofar as they attempted to actively pursue their desires: a 'healthy' woman was synonymous with a diseased human (Weisstein 1971, Chesler 1974, Phillips & Segal 1969, Broverman et al 1970). And further, women's active expression became subject to wholesale attack as disease analogised the death of individuals, and in terms of the biocultural dialectic, of society. Women's efforts to participate in essential human activity on an equal basis with men therefore sounded the death knell for patriarchy.

Women's active search for relief from the oppression of everyday life, therefore, finds public expression in the form of individual disease. The organic analogy that was instrumental in

the establishment of the welfare state has meant that social practices which express social disorder (such as drunkenness or women's active inabstinence) have been organically domesticated - as individual dis-ease. This analogy, therefore, has facilitated the establishment of social order based on an assumption of utilitarian consensus: the greater the number of healthy individuals, the greater the health of society. Social disorder was analogised to individual disorder, and treatable through medical intervention. The organic analogy, therefore, reduced social and economic structures to individual structures, and thus of social diseases to individual dis-eases. And doctors, within the context of a growing concern for social health, became the locus of the presentation of a vastly expanding array of symptoms of 'living', such as anxiety, insomnia, depression and grief (Smart 1984, Zola 1972, Dowsling 1977, Room 1972, Cooperstock 1977).

".. there is hardly any doubt that professionals, through their expansion of psychiatric conceptualizations to include anxiety, unhappiness, conflict and tension as symptoms of mental disease, have themselves contributed significantly to the very psychic distress they seek to pacify through drugs. Both mental health professionals and the pharmaceutical industry have, by promoting drug-taking, promoted a model that has

contributed significantly to the medicalisation and technocratisation of human existence." (Lennard & Bernstein 1974).

And, as more time and money was spent by society in the production and consumption of medicine as a commodity, the greater the belief that it has a supply of "health locked away" (Dowsling 1977): optimistic and expansive medical technology promises a new and improved life "just around the corner" commensurate with the consumption of such technology in ridding us of discomfort (Willowroot 1983).

Women's more frequent appearance in the doctors surgery (Gove & Tudor 1974, Dunnell & Cartwright 1972, Cooperstock 1972, 1975, 1977, Nathenson 1975, Reid & Wormald 1981, Kessler et al 1981, Brannen & Collard 1982), therefore, as an expression of their social dis-ease is transmogrified into individual pathology. Women's statistically greater propensity to dis-ease is conceived as an objective manifestation of women's pathological repression of their essential self/desire (which is passively realised in their consumption by men). Doctors increasingly received the expression of women's feelings, which, true to the principles of voluntaristic medical practice

(chapter 3) (Busfield 1988), somehow become 'diseases' by definition, if only because they are presented in a doctors surgery (Cooperstock 1975, Room 1972). In particular, women are medically conceived as experiencing significantly more mental disorders than men (Cooperstock 1972, Gove & Tudor 1974). Within the optimistic and self-fulfilling parameters of medical practice doctors prescribe women with significantly more psychotropic drugs, particularly tranquillisers (Cooperstock 1975) than men in an attempt to relieve their dis-ease.

Within the terms of the functionalist analogy, women's greater appearance in the doctors surgery is taken as tautological proof of both women's greater pathology, and also as women's experience of illness is positively correlated with the development of permissive liberalism (chapter 4), it is taken as proof of the pathological nature of the (forced) institution of women's 'equality'. The liberal encouragement of women's inabstinence in terms both of their economic participation and of the general availability of "hazardous commodities" such as alcohol (Room 1983)

(facilitating women's participation in leisure/
/pleasure) is therefore seen as functionally
causing women's greater disease (chapter 4) due to
their denial of their essential 'feminine'
passivity. Women's illness is conceived as the
"ransom of their emancipation" (chapter 2).

Contemporary social health and welfare services,
therefore crystallize the organic functionalist
analogy, thus remaining with the evolutionary
premise that women are fundamentally different
from men. In particular, that as women are
organically enthralled to their bodies, they are
less expressive of human desire than men. Thus the
permissive institution of continuity/equality
between men and women was regarded as
"atavistic" in its neglect of essential human
differences. The functionalist analogy also
regards the notion of women's equality with men,
insofar as it represses women's essentially
passive nature (which, in turn represses men's
essential nature in their consumption of women) as
pathogenic (to women and men). Thus the functional
re-establishment of an 'organic' hierarchy between
women and men: to be 'healthy' women must be

express their essential difference from and
consumptive subordination to men.

Contemporary women, therefore find a form of "time
out" from the "tedium of women's works" (Wolfson &
Murray 1986) through their formal definition as
"sick"⁵. In the form of the doctors prescription
for drugs (often psychotropic drugs, such as
tranquillisers (Cooperstock 1975)) women's are
granted a reprieve from productive activity for
the duration of their sickness. Ironically,
however, women's reprieve re-enforces women's
functional abstinence from public activity, whilst
their consumptive activity (passivity) at home is
analogies in their consumption of tranquillising
drugs.

Women's medical help-seeking, therefore, draws
them into a more consensual form of domestic
isolation: women's are legally free to engage with
the publicly productive world on an equal basis
with men, their illness, however excuses their
equal participation. The medicalisation of women's
'problems of living', therefore, not only
amplifies women's dis-ease, but re-enforces their

their characterisation of 'femininity' (Chesler 1974). Medical intervention amplifies women's intrinsic pathology/deviance, and thus, insofar as that is conceived in terms of natural feminine characteristics, amplifies women's femininity. Women's dependence upon doctors and drugs in order to cope with the demands of their roles caricaturises and further consolidates their functional dependence upon patriarchal society.

Women's consumption of drugs, therefore provides them only with an individual and temporary means of *escaping* their feelings rather than *expressing* them: they escape their feelings of isolation, emptiness, guilt, low self-esteem and anger (Ettorre 1986) (chapter 3), but lacking a collective social identity, drugs merely deny women the opportunity for the active pursuit of pleasure: women's consumption of drugs assures men's active (pleasurable) self-actualisation through their consumption of women.

"It is monstrously more difficult for women to escape (even temporarily) and .. [men's] symbolic flights have often been at the expense of women.." (McRobbie 1980, p45)

Thus whereas alcohol/drugs provide leisure/.pleasure/"time-out" to men (chapter 4), women's

drug consumption provides no such respite or
"imaginary solution":

".. it seems evident that if women are at home they never really have 'time-off' - their availability to children [and men] is assured. Any pleasure to be gained from other sources is a diluted experience if it always takes place in [this] context.." (Hey 1986, p20).

Women who "self-prescribe" (Cooperstock 1975) alcohol and drugs in an attempt to find "time-off", consequently lack any collective means for expressing their dis-order in terms other than those of the prevalent organic gender ideology. Thus,

".. scalpeled off from society, .. exist[ing], and understandable only within the narrow limits of [their] personal pathology, [their] behaviour is circumscribed within a medical metaphor." (Young 1971, p85).

Not only health, therefore, but the related activity of drug-taking is experienced in gendered terms. As the functionalist/organic consensus therefore came under increasing strain through the failure of permissive liberalism (such as women's equal participation in employment and in leisure/pleasure) to re-enforce the "collective conscience", the demand for relief of dis-ease through the health and welfare services increased

with a concomitantly pathological rate of drug and alcohol consumption.

The (gender skewed) medicalisation of social problems has meant that the demands on the National Health Service have not reduced. As the demand for licit and illicit psychotropic drugs increased through the 1950s and 1960s, health and welfare services found themselves under increasing strain. Alcoholism (as an addictive disease (chapter 3)) became designated as a treatable disease in 1962 (Ministry of Health 1962). This empowered GPs to deal with the problems of excessive alcohol consumption and also led to the establishment of regional Alcohol Treatment Units attached to psychiatric hospitals. However, as the incidence of alcoholism seemed to increase with the development of the notion of Alcohol Dependency Syndrome (chapter 3), the medical/psychiatric establishment began to conclude that specialist in-patient psychiatric treatment could deal with only a minority of the target population of alcoholics/problem drinkers. And by 1973 the new focus of intervention was on

excessive drinkers with problems, rather than alcoholics.

".. [I]t would appear, indeed, that there is no one cause of alcoholism - social, cultural, personality and physical factors may all contribute. Alcoholism appears to be a medical-social problem in its origins and in its manifestations, and as such, it is probably best tackled by a medical-social approach." (DHSS 1973)

As socio-cultural reform at an economic level failed to resolve the problem of social dis-ease and dis-order, the bio-cultural dialectic enabled reformists to focus afresh on individual processes of (moral) learning: intervention in alcohol drinking and drunkenness returned afresh to psychology. This new 'multifactorial' approach to drinking and drunkenness rested on an analysis of the development of drinking problems which combined operant (chapter 3) with cultural analyses (chapter 4):

"Since alcohol is a relatively ineffectual addictive agent which usually takes years of hard drinking to bring about a process of true addiction, *the reinforcing properties of alcohol need to have a strong helping hand from personality and cultural factors...*" (Cahalan 1987, p68, my emphasis).

Thus, the "interaction" of the individual with her cultural environment became the focus for the development of the modern attack on drunkenness and inabstinence. In particular, *individual*

beliefs about alcohol, drinking and drunkenness were conceived as the "most powerful predictor" of problem drinking. The ostensibly objective reality of alcohol-related-harm was now to be explained in the individual subjective definition of that reality (Thomas 1967). Perniciously, the new paradigm for understanding and treating harmful drinking meant that actual drinking patterns may change and 'normalise', but the pathology remains. Pattison (1976) for example, contended that although an individual may learn to control her drinking or even become alcoholically abstinent, her "life health" (in terms of the moral value attached to drinking) may be no better: whilst the actual drinking changes, the *meaning* of drinking does not necessarily change:

".. the alcoholic has not changed his *symbolic perception of the meaning of drinking..*" (Pattison 1976 p184, his emphasis).

According to the new liberalism, therefore, some individuals, although they may appear to be equally healthy (insofar as they drink in a normal, acceptable manner) are in fact pathological in the meaning which they invest in alcohol. The social dis-ease expressed through drug use and the demonstration and experience of

individual sickness, therefore, was further abstracted: social dis-ease was not simply expressed in terms of individual dis-ease, but further internalised, psychologised in terms of the specific "health" values of the individual.

The meaning of an individual activity, such as drinking, was conceived in the interaction of individual physiological factors with cultural factors (Lemert 1951). According to such a bio-cultural dialectic

".. a two-way process occurs in drugtaking: the drug alters the metabolism of the individual, he interprets these bodily changes according to his expectations, social situation and prevailing mood, and these subjective experiences react back to change the already altered metabolism. In short, the drug experience can only be understood in terms of an ongoing dialectic between the subjective mood of the individual and the objective psychotropic effects of the drug." (Young 1971, pp36-37).

As such, *the development of healthy drinking is seen as requiring a cultural context which provides symbolic as well as behavioural drinking norms* (Becker 1967). A culture which interprets the effects of alcohol as pleasant (or at least normal) will enable the drinking individual to feel in control of her situation; if, however, a culture provides no guidance on the social and

individual form of drinking, the drinking individual will feel that she is out of control - even though she may appear to be 'normal'. Thus, insofar as alcohol is culturally available and invested with a socially acceptable meaning, it will engender healthy drinking (chapter 4). And insofar as the symbolic means of normalisation are unavailable to individuals, they will develop harmful drinking - even although they appear to conform to the behavioural norms of drinking.

Within contemporary Britain permissive economic policies render alcohol a freely available commodity, widely acceptable as a means of leisure, of "time-out" from the "otherwise imperative demands of everyday life" (MacAndrew & Edgerton 1969) (Chapter 4). Drinking alcohol is culturally valued as

".. a symbolic punctuation mark differentiating one social context from another." (Robinson 1976, p4).

The 'meaning' of drinking is constructed in terms of the publicly productive culture of waged labour and the culture of consumption: contemporary drinking enables the individual to move out of the former and into the latter, and in doing so to

realise his essential humanity/masculinity (Chapter 4). The behaviour of drinking, therefore, as a "punctuation mark", depends upon its context for its meaning. In the absence of that context, drinking remains devoid of meaning, and thus of social form. And insofar as it is a "trip-switch" (Willis 1975) from labour to leisure, drinking alcohol depends, for its social form, on the domain of both. The intercourse of labour with leisure is described in the activity of normal pub drinking: the activity of round buying, in particular, can be seen as symbolising the participation of all members of the round in *both* labour *and* leisure.

"Round-buying provides a reflection and proof, within the sphere of consumption, of ones .. position within the sphere of production. Work in the labour market involves an acceptance of the wage relation - ie it involves acting *as if* one were a free an independent agent, equal to all others in the market - and the round provides a means of affirming and celebrating this relationship...

And the thought of breakdowns in the assumption of independence elicits generally-formulated statements of dis-ease...

Obligations are incompatible with independence. It needs however to be stressed that what is being celebrated in the round is not some 'value' of independence-in-general, but the specific form of independence that corresponds to the aspirations and commitment to the labour market. In the context of an orientation to the social relations of the labour, the round system has

two advantages over the alternative possibility of each person buying his or her own. In the first place, round buying demonstrates the independence and *equality* of each party, since it involves full reciprocity; whereas buying one's own indicates independence, but not necessarily equality (of status, of means). Secondly, buying a round of drinks is an action that demands the attention of all those involved, and draws attention to itself in a way that buying one's own need not. Each time a round is bought, each person in the round must signal his or her preference for type or size of drink, or if type and size of drink is a fixed custom, must at least signify whether or not he or she agrees to accept another drink; and each person acknowledges the drink, or receipt of it. The round therefore, necessarily involves repeated *public* acknowledgement of the social relations of equality in the round-buying group." (Dorn 1983 p180-181, his emphases).

Insofar as round-drinking in pubs provides the paradigm for normal drinking, independent or solitary drinking symbolises negatively the inequality and the public non-existence of the drinker. Individuals only have the capacity for normal drinking insofar as they are free and equal to engage in both (waged) labour and leisure as these activities are symbolised in the drinking round.

The pub, however, like wider society, is far from a gender neutral place. Women's participation in pub drinking is tightly circumscribed in term of their sexuality. The patriarchal control of the

pub - and of hence of 'normal', legitimate drinking (chapter 1) - is evidenced in the rarity and formal nature of women's participation in the pub (Leonard 1980). The "natural alliance between publican and prostitute" (Harrison 1971) provides a context for the

".. very pertinent sense [in which] any active woman .. can be seen as a prostitute." (Hey 1986, p56).

Thus, insofar as the pub provides an arena for the collective consumption of women by men, it provides a key social expression masculinity.

"The ideology of increased physical potency encouraged men to consume and the ability to 'take one ale' became imprinted as a mark of masculinity ... [simultaneous with their] consumption of prostitutes in drinking places." (Hey 1986, p28)

The round-drinking paradigm, therefore defines 'normal' drinking in masculine terms.

Where normal (pub) drinking and drunkenness is a collective and symbolic means of expressing masculinity through both the real and collective consumption of alcohol and the symbolic and/or material consumption of women, femininity is expressed only through masculine consumption. In a normal drinking situation, therefore, women admissible only insofar as women service men - as

barmaids, prostitutes or as nurses (McRobbie 1980, Auld et al 1986) or in being 'chatted up' by men, listening to them. Drinking, for women, therefore, is only legitimate insofar as it reinforces women's abstinence from "pleasure/noise/sexuality/presence": in short, women's drinking is only legitimate insofar as it expresses their dependence upon men.

"So intransigently male are the mythologies and rituals attached to regular drug taking that few women feel the slightest interest in their literary, cinematic or cultural expressions - from William Burrough's catalogues of destructive self-abuse and Jack Kerouac's stream of consciousness drinking sprees to Paul Willis's lads and their alcoholic bravado. It would be foolish to imagine that women don't take drugs - isolated young housewives are among the heaviest drug users and girls in their late teens are one of the largest groups among attempted suicides by drug overdose. Instead I'm suggesting that for a complex of reasons, the imaginary solutions which drugs may offer boys do not have the same attraction for girls. One reason is probably the commonsense wisdom deeply inscribed in most women's consciousness - that boys don't like girls who drink, take speed and so on; that losing control spells sexual danger; and that drinking and taking drugs harm physical appearance." (McRobbie 1980, p.46)

The patriarchal boundaries drawn around "female solidarity, pleasure noise/sexuality/presence" (Hey 1986) are demonstrated in absence of women's pub(lic) collective activity. Even occasional attempts by women to express pleasure/leisure,

such as women's bingo evenings, are subject to sexualised sanctions: any women seen to be engaged in public activities other than, for example shopping or hospital visiting are subject to rumours of having cuckolded their husband (Whitehead 1976). Such rumour mongering effectively censures and controls their movements, supporting the expression of masculinity through men's enforcement of their wives abstinence.

Women, therefore are defined in their isolation, whilst men find definition in groups. Women's inability to "mobilise as a group" means that the acquisition and expression of femininity is a much more privatised experience than the acquisition of masculinity (Leonard 1980, McRobbie & McCabe 1981, Connell et al 1981). Masculinity, by definition,

".. requires men to identify with their own sex in an equivocal allegiance that excludes, fragments and abuses the female sex. The pub culture exemplifies these social processes." (Hey 1986 p72).

Femininity, however, is defined in the isolation of women from each other: in women's abstention from active and public social activity:

"Women are people with no groups" (Leonard 1980)

And consequently, insofar as collective experiences engender cultural symbols, women's experience achieves symbolic recognition only in intercourse with men: women have no access to even symbolic means of independent pleasure/leisure. Women's health and social presence, therefore, is dependent upon their deferral of gratification to men: insofar as they fail to express their organic abstinence in their domestic isolation and dependence upon men, they will become ill and/or subject to sexualised social sanctions.

Women are thus conceived as dependent on the very substance of society: their economic and emotional dependency on "a man, men, male protection or male professionals" is accepted and encouraged (Wolfson & Murray 1986, Ettorre 1986). The material position of most women is characterised by economic dependence: state restriction of abortion and childcare, and women's traditional responsibility for unpaid domestic work, and tax and social security systems based on 'family units' rather than individuals all indicate the division of the social systems of public, paid employment from those of domestic, unpaid work

(defined around the abstinence of women and their consumption by men) which lead to women's economic dependence on men (Perry 1979). Furthermore, the functional promotion of an "acceptable degree of passivity and dependency" as a natural and essential female characteristic, and the widespread isolation of women at home is seen as predisposing women to seek individual, privatised methods of relieving dis-ease, and thus to psychological and/or physical dependency. Collective solutions, therefore, to such dis-ease, such as fraternal drinking are not available to women.

Women, therefore, are denied the capacity for normal drinking insofar as they are dependent on men; and women who, therefore resort to drinking at home rather than in (the) pub(lic) as a means of relief from dis-ease are defined *per se* as deviant or harmful drinkers. 'Normal' drinking and drunkenness, therefore are conceived as a masculine activity: drunkenness does not have either the same form or the same meaning for women as it does for men.

".. the *maximal openness* of the senses and essential *lack of autonomy* felt on the drug experience ...

The loss of the ego, the loss of protective reflexes and openness..." (Willis 1975, pp 111-112, my emphasis).

This description of drunkenness explicates the organic conception of normal femininity: *women are conceived as intrinsically drunk* insofar as they are dependent and open and available to men. Women are functionally conceived as the means of the patriarchal leisure, and thus of the expression of essential humanity/patriarchy. Furthermore, the pervasive conception of women as creatures determined by the vagaries of their bodies, and thus incapable of fully intending their own actions (Gelsthorpe 1989, Hutter & Williams 1981) is also characteristic of the drunken experience. For men, the drug experience may symbolise a "fundamental ontological change" from a sense of feeling "self as an autonomous determining agent" to feeling self as "in part a determined variable in the world": this temporary change provided the possibility for a sense of liberation from "coercion in the public world" (Willis 1975)

"This encapsulation by the 'now', and the feeling of freedom to 'walk around in the moment', led to a total breakdown of conventional notions of time. Industrial and job-oriented time is crucially concerned with order... This subjective sense of time, the

maximal openness of the sense and the essential lack of autonomy felt on the drug experience, could dispel normal senses of revulsion: objectively distasteful situations became pleasurable and even fascinating" (Willis 1975, p111)

Drunkenness provides men with temporary respite from responsibility through the "*belief* that 'its the drugs, not me'" (Willis 1975); for women, however, the experience of drunkenness (like the experience of sickness) simply reinforces their bodily as well as social (bio-cultural) "lack of autonomy". Drunkenness, therefore, describes the experience of specific men at specific times; but is analogous with the feminine norms defining all women. It is a gender-specific experience:

"Both conditions - being stoned and being straight - are constructed as experiential states through the mediation of sexual identity and social relations." (McRobbie 1980, p46).

Widespread social concern over women's inabstinent drinking arises when it is regarded as

".. upsetting the balance between women's appropriate economic dependence and the requirement for responsible and accountable domestic functioning." (Perry 1979 p1)

When this happens, women's "drug dependence" is seen as an inappropriate side effect of women's social dependence which should be "re-directed to more convenient and controllable forms of dependence". The treatment of women's

inabstinence, therefore is to 'rehabilitate' or "pressurise" them into a moral and emotional commitment to economic powerlessness and an acceptance of the "consolation prize" of the home.

"Dependence of women on men is seen as destructively diverted for the female addict; the inevitability and lack of choice consequent on this 'natural' dependence is converted into a fatal decline... The benign dependence of woman on men is transposed to the malignant dependence of addict on pusher. The 'fatal inevitability' of this parody of acceptable social relations allows considerable sympathy to be extended to female addicts who are not considered to be responsible for their actions." (Perry 1979 p4)

Women's dependence on drugs, therefore is seen as natural but misplaced. It is simultaneously inappropriate ("the passive should not need pacifiers") and "only to be expected" (the passive also need the strength to resist) (Perry 1979).

Feminine norms, therefore, are embedded in the functionalist notion that women differ from men in their dependency and 'drunken' "incapacity to govern themselves" (Hutter & Williams 1981).⁹ As such, differing behavioural norms for women and men are conceived as *protecting* women from any pathological inabstinence, such as public drinking and the active expression of sexual desire. The

"double-standard" of drunkenness (Otto 1981, Burns 1979, Mulford 1977, Schmidt & De Lint 1969), therefore is seen as protecting women from the harmful effects alcohol. This "double standard" provides a double-sided stereotype of drunken women - both as caricatures of 'normal' women. On one hand, the double standard characterises drunken women sexually as 'sluts', and on the other, they are stereotyped as pathologically dependent (Harwin & Otto 1979, Perry 1979). Insofar as drunken women are seen to be actively choosing to be incontinent (rather than intrinsically pathological) they are censured for "selfish, pleasure-seeking behaviour", condemned as "sluts, totally devoid of all self-respect" (Harwin & Otto 1979), and thus sexually available to all men. Drunken women are thus conceived as consenting to their public (rather than private/marital) patriarchal consumption. Simultaneously, drunken women are stereotyped as pathetic, passive, psychologically and socially inadequate, isolated and incapable of taking any responsibility (including self-responsibility): as sick, sub-human creatures, devoid of the sexual connotations of femininity (Harwin & Otto 1979, Perry 1979).

Either way, inabstinent women are stereotyped in terms of the feminine norm: on the one hand they actively express "uncontrolled feminine sexuality", but on the other, they caricaturise the dependency of normal femininity⁷.

Consequently, women's drunken inabstinence is conceived in terms of their "essential" pathology as a "cry for help" (Gelsthorpe 1989). Such women are conceived as requiring individual help and understanding in coping with their essential instability which predisposes them to "undesirable influences" and renders them "incapable of resisting temptation" (Perry 1979). In particular, the liberal advocacy of women's equality with men is seen as damaging the organic/functional stigma that is associated with the drinking double standard. Women's abstinence from drunkenness is conceived organically, in terms of women's greater vulnerability to the negative effects of alcohol (chapter 4) (Allan). Women's emancipation, however, is conceived as destroying women's bio-cultural protection from alcohol and drunkenness. Women consuming alcohol in increasing amounts, however, the traditional organic stigma attached

to drunken women is regarded as inhibiting them from seeking help for their dis-ease.

Furthermore, the organic persistence of the stigma against women drinking also "protects" them from public definition as alcoholics or drunks (Otto 1981, Schmidt & De Lint 1969, Fraser 1975, Levy & Doyle, Gomberg 1974, Burns 1979, Woodruff et al 1973, Greenblatt & Schuckitt 1976, Johnson 1965, Lindbeck 1972, Wilson 1980, Avon Council on Alcohol 1982, Sheehan & Watson 1980). Explicit public intervention in women's inabstinence is regarded as exacerbating the internal contradiction between "emancipated" women's social experience and their organically abstinent natures. Drunken women, therefore, remain a largely 'invisible' force in society; however, the development of psychological and epidemiological analyses of drinking and drunkenness (chapters 3 & 4) predict a positive epidemic of alcohol-related-harm, particularly among women.

The solution to the epidemiological identification of an epidemic of drunkenness (Ferrance 1980)

(chapter 4) was to stage public and professional (Isaac & Moon 1985) education campaigns making

".. it easier for both lay and professional people to detect alcohol problems and encourage those with drinking problems to feel more secure about coming forward for help." (Otto 1980, p158).

And the influence of interactionalist perspectives in social science research facilitated a 'treatment' focus on the import of the reaction of (sober) others to drunken individuals:

"The major explanatory factors may not lie within the drinkers themselves, but within the relationships between drinkers and those who respond to them." (Shaw et al 1978).

The 'social context' of the individual recognition of alcohol-related-harm became more significant (Pinder 1977), and social welfare reformers turned their attention to health/temperance education within "lay" and "professional networks" (Brown 1980, Avon Council on Alcohol 1982, Shaw et al 1978, Isaacs & Moon 1985, Pinder 1977, Thom 1984, 1986a, 1986b). Specific alcohol education campaigns became increasingly important in both raising the awareness of the general populace and of health and welfare professionals.

".. professionals may too readily agree with women on alternative explanations for their difficulties.. [and] .. a patient or clients failure to perceive alcohol as a problem may be interpreted as 'denial' or 'lack of

motivation' and taken a licence for non-intervention." (Thom 1986a p787).

The 'social context' of recognition of alcohol-related-harm extended to the 'public face' of agents of recognition/definition: specific alcohol and drug agents are perceived as relevant only to men - to the extent that not only do the professionals working within them fail to respond to women clients^a, but also to the extent that the male intimates of such inabstinent women may actively hinder their attendance. Several researchers have observed that women are likely to experience indirect and direct attempts by their male partners to prevent them seeking alcohol treatment (Fox 1963, Isaac 1986b, Thom 1986b), as (in terms of the organic stereotypes) the husband of an inab^bs[^]inently drinking wife is regarded as lacking in masculinity - cuckolded. Furthermore, the "case-work" approach of the health and social services entrenched in organic assumptions which provide few means for identifying, far less 'treating' women as drunks.

Social welfare intervention extends the individual 'case' (Levine 1975, 1977) approach of medical intervention (chapter 2) to crystalise the bio-

cultural premises of the functionalist conception of society. The emphasis on individual personal inadequacy/pathology and adjustment and on the construction of dependency of the 'client' upon the worker (Levine 1975, 1977) describes in microcosmic detail the functional definition of women, in particular, their abstinent roles as wife and mother (Isaac 1975, 1986b, Smart, Perry 1979).

"This .. is based on the assumption that the woman who accepts her traditional role, who is passive, gentle and caring, is also non-[deviant]. Conversely the rationale assumes that the emancipated woman is masculine in her attitudes and behaviour is consequently more likely to act in a [deviant] fashion. Seen in this light the policy of re-confirming the traditional role of women, the training in domestic or basic manual skills only, is an attempt to prevent recidivism and to rehabilitate the female offender into a socially approved [inabstinent] role." (Smart p142).

The 'treatment' available to dis-eased women such as drunks, therefore, aims to restore individual fitness and healthy social balance through their "commitment" (chapter 3) to their functional role.

"Popular mythologies of the female addict are paralleled in their treatment... A survey of residents at Eagleville (USA) showed that practically all the women considered job training to be their greatest need, while nearly as many wanted to continue their education. Staff, however, felt that *women needed mainly psychological help with personal and emotional problems...* Despite

isolated attempts to analyse and eliminate sexism in rehabilitation, *the focus remains on issues of psychology and sexuality...* [The] battery of negative moral attitudes ensures that only those women prepared to accept their drug problems as symptomatic of personal 'sickness' will seek help from official agencies...

Reactions towards female drug users are based on accepted tenets of the 'proper place' and behaviour appropriate to women. Their unpaid labour in the home is subject to neither market forces nor overt public control, but rather to moral exhortations to exercise *self-control and [abstinent] responsibility.*" (Perry 1979, p4, my emphasis).

Drunken women, therefore, are conceived as

".. essentially emotional, immature, manipulative and child-like and yet at the same time they are seen as deviant in terms of appropriate female behaviour - in other words, as sad or mad but never bad, for this would be to regard the woman as responsible for her own behaviour." (Otto 1981 p163).

In particular, drunken women are regarded as having no control over her sexual and reproductive capacities, such that her "natural" maternal characteristics are lacking.

"Control over women's reproductive function is manifested not only by relative availability of contraception, abortion and obstetric facilities but also by a public concern with the mother's individual responsibility for the health of her baby... The female addict is characterised as a selfish and unfit mother by reason of her drug use...

Official bodies in the USA recognize the economic consequences: 'there will be occasions when substance abusing mothers cannot be expected to fully assume the responsibilities of their children. In such situations *the community will often have to*

bear the cost of protecting these youngsters'. (Perry 1979, p4, her emphasis).

Perry (1979) indicates the social cost of women's inabstinence - implicitly acknowledging the functional significance of the domestic privatisation of childcare and the organic correspondence of women with children.

Inabstinent women's subjection to public control and consumption, either through medical/welfare intervention or through sexual violence (Corrigan 1986, Bailey 1985) consequently restates their 'organic' dependence upon men - as 'natural' protectors and providers. The pervasiveness of the control of women suggests that women's struggles to challenge the oppression of the organic analogy and their functional role represent a particularly strong threat to existing social order (Hutter & Williams 1981). However any potential threat that unabstinent women may pose to the stability of the social structure (such as their denial of patriarchal expression through their own active expression⁷) is domesticated through the intervention of social welfare agents *backed up by the threat of violence*⁸.

"The social control of women assumes many forms.. the problem [is] of showing the

existence of specific *covert* forms of oppression and control, and of revealing that their location lies in the public sphere rather than in the individual psychologies or personal lives of oppressed women... Undoubtably .. the more difficult forms of social control to address, especially with the ellipse of more manifest forms of sexual discrimination, are those that arise implicitly through socialisation." (Smart & Smart 1978).

Of particular importance in the control of women is the concept of essential sex differences, which 'naturalises' the enforcement of women's abstinence through their isolation in the home concomitant with their divorce from waged labour¹⁰. This indicates that the social control¹¹ of women through abstinence

".. assumes both material and ideological forms and occurs in both private and public domains". (Smart & Smart 1978).

Women's criticism of the enforcement of their abstinence and the expression of their discontent can be "incorporated" (Perry 1979) through social welfare intervention up to a "threshold" beyond which any 'anti-social' disordered behaviour (such as drunkenness) is conceived as symptomatic of widespread social dis-ease. Such an 'epidemic' would herald the terminal malaise of society. And, insofar as society is based upon women's abstinence, large numbers of women cannot be seen to be *actively choosing* "dysfunctional" behaviour.

As long as inabstinent women are conceived as isolated individuals who have particular difficulties in adapting to society, epidemic/revolutionary proportions of dis-ease may be contained. The modern attack on dis-ease (Sontag 1978), therefore, rests upon the assumption that dis-ease is caused by individual special needs, conceived in a gendered form: masculine disease cause by the failure of the individual man to express himself (through consumption), and feminine disease caused by the failure of the individual women to realise her true nature in deferring her pleasure (chapter 2) in order to be healthily consumed by men. Dis-ease, in short, is defined in terms of the individual's acceptance of gender ideology. Hence the transmogrification of women's active drunkenness - as the active pursuit of leisure/pleasure - into a pathological caricature of women's essential dependence. The pre-modern possibility of drunkenness as political activity has been domesticated into its male form of "time-out" and its female form of dependence.

The contemporary concern to attack alcohol-related harm/dis-order through the extension of the domain of the health and social services can be seen, therefore, as a means of reinforcing the roots of the health and welfare services in nineteenth century 'temperance education'. The Kessel Report (Kessel 1978) extended the realm of alcohol-related-problems to include individuals other than the drinker, such as those involved in drink-driving accidents, work days lost through drinking etc.

"[Individuals who experience alcohol problems include] those with drinking problems (or those at risk of developing drinking problems), whatever their extent and whether or not they are considered alcoholics, and .. members of their families and others personally affected." (Kessel 1978)

Thus the exponential increase in alcohol-related-problems. The Kessel Report recommended not only the involvement of the generic social services in alcohol-related-problems as well as the medical profession, but also the development of "comprehensive community based" alcohol services. Community Alcohol Teams were established to deal with (attack) alcohol problems at a local community level and thus before they became medical problems. Thus the maintenance of high

(and increasing) levels of demand on the Welfare State, and the failure of the fiscal measures to generate sufficient income for the level of services required to deal with social dis-ease.

Comcomitant with the Kessel Report, the Central Policy Review Staff report (1978) was produced. This promoted the development of health education material on alcohol-related-problems (chapter 4).

"There is a growing and convincing .. need not to teach about alcohol(ism) problems, but about the attitudes and pressures associated with drinking in contemporary society and the nature of decisions about its consumption."
(CPRS 1978, p67)

In addition to the intervention of the health and welfare services in the attempt to eradicate alcohol problems, the development of a health care rhetoric emphasising individual responsibility, discipline and self-help (Dorn 1983) in the 1980s and 1990s crystalised the functionalist tendency to focus on the individual in dealing with social disorder. The individualist health care rhetoric became increasingly significant as the fiscal crisis of the welfare state expressed the problems inherent in the organic functionalist conception of society and social problems. Community based and health educational initiatives in the

prevention of alcohol-related-problems established professional and lay-networks and partnerships in the early identification of alcohol-problems (Cartwright et al 1975); and health education campaigns outlined individual 'risk-factors' in the development of problem drinking (Robinson 1976), enabling the individual herself to identify her disorder. Controlled drinking was the prescription for identified and non-identified problem drinkers as the professional consensus was now that

".. it is impossible to distinguish precisely between 'safe' and 'normal' drinking." (Shaw 1982)

In this way general social consensus was maintained, although in a different form from that of the 1950s - 1970s. The populace was now actively involved as partners in the establishment of social control (the absence of dis-ease): the medical domination of alcohol intervention dissolved in the face of increasing criticism over its efficacy (chapters 3 & 4), becoming instead a back-up service, a safety net for particularly uncontrolled individuals - such as women.

Current attempts to identify and 'treat' drunken women, therefore oscillate between patriarchal needs to control women, and the liberal humanist concern for the amplification of women's dis-ease through their invisibility. Whilst the social form of men's drunken dis-order is socially visible it contains the possibly for political protest against repressive social relations (Denzin); the organic conception of women as "bodily enthralled" however, provides no such possibility¹². Men's drunken disorder is likely to be explicitly and publicly sanctioned - they may be legally coerced into sobriety (Allan 1987); however, the stereotype of women as more vulnerable and in need of more care (Gelsthorpe 1989) than deviant men means that their appearance at alcohol agencies is both less frequent and less explicitly coercive.

"Women for a variety of social and cultural reasons are less likely to commit offences while intoxicated, be subject to disciplinary procedures at work or become homeless. Because of this they are less likely to be referred from the coercive sources which in varying degrees provided the powerful pressures for men to remain in counselling" (Allan 1987, p.1147)

The sanctions enforcing women's abstinence are therefore defined in private rather than public terms. Social intervention, therefore, in women's

inabstinence is at the level of the private life of the individual, rather than in public punishment for non-conformity. The solution to the threat of social dis-order that inabstinent women embody, therefore, is defined in terms of women's acceptance of their essential abstinence. However, in the correspondence of the experience of drunkenness with the experience of femininity (the only difference is in the functional form of abstinence), inabstinent women may remain undetected.

Drunken women's persistent invisibility - in the alcohol literature, in the alcohol agencies, and in society - effectively "telescopes"¹³ (Gomberg 1979, Elder 1973, Badlet 1975, Curlee 1969, Schuckitt 1972, Schuckitt & Gunderson 1975, Lindbeck 1972) the negative effects of alcohol and drinking on women. The "latent function" (chapter 1) of health and welfare intervention, therefore is a form of covert institutional violence: women are physically damaged through the efficacy of organic models of society. Furthermore, the stereotype of drunken women as sexually promiscuous (Cartwright et al 1975) coupled with

the stereotype of drunken men as aggressive (Cartwright et al 1975) provides organic justification for men's (sexual) aggression to (drunken) women. Drunken women's invisibility as a function of their organic caricature, therefore provides a violent "back up" to more consensual form of social control.

Inabstinent women may thus become "nondescript" (Worrall 1990): they are subject to processes that subject deviant women to the needs of health and welfare agents to categorise them within the terms of organic/functionalist constructions of femininity, in particular women's functional (maternal/sexual) role in nurturing others (Isaac 1986b). Not only are the outcomes of these processes inappropriate and unsuccessful (Allan), but also unabstinent women's failure to 'fit' such professionally defined categories means that they are both neglected by and to some extent 'free' of specific professional control (Worrall 1990). Through the discourses of health and social welfare agents and of temperance/health education initiatives, women are "strategically constructed" as "programmable objects of professional

discourse" wherein they are effectively offered a contract which promises to minimise the consequences of their deviant by rehabilitating them within the dominant conceptions of femininity (abstinence, dependency, pathology). Some inabstinent women (chapter 8) succeed *to some extent* in resisting "programmes of feminisation" by exploiting their "non-descriptness"¹⁴. Their grasping of their "non-descript" status provides some women with the potential to undermine the authority of "professional discourses" and maintains the possibility of new knowledge of inabstinent women. However, the power of "professional discourses" are such that women resistance remains at an individual level, is usually inconsistent and sometimes self-destructive (chapter 8).

The organic/functional conception of women as the privatised locus of consumption, defined in terms of their sexuality and intrinsic pathology, therefore, paralyses the political possibilities of their inabstinence; and further "the essential lack of autonomy" (Willis 1975) characteristic of drugged consciousness mimics women's organic/

/patriarchal determination. Women's functional abstinence is maintained, therefore, despite their consumption of alcohol and drugs: in their dependence upon alcohol/drugs women are further inhibited from collective active expression, and their availability to men is affirmed.

".. the parameters of female sharing and pleasure are very tightly drawn, both in their observation and in their disruption."
(Hey 1986 p.51).

CHAPTER 6:

DEFINING A STANDPOINT

My thesis is that the social control of women occurs through the construction abstinent femininity as the interstices of psychiatric, psychological and sociological/functional discourses. In particular, I have been concerned to explicate how 'rationality', 'objectivity' and 'liberalism' have become key aspects of the three discourses that are particularly influential in controlling drunken women. At this stage in my argument, I am concerned to show how research methodology may also become part of the sociological discourse controlling women, specifically in processes of categorisation that may render women's experiences "non-descript" (Worrall 1990). As in the processes of social intervention in women's deviance however, women's "non-descriptness" may provide some potential for political action, particularly, as I will argue, if a clear research "standpoint" is taken.

In doing social research, two main questions are at issue: firstly, the extent to which the research examines what it sets out to; and second, the extent to which the means of research are scientifically reliable - that is, the capacity of the methods to measure accurately or consistently the same phenomenon under different conditions. There is a tension between the validity and the reliability of any social research, which can be clarified by specifying the epistemology, or "justificatory strategy" (Harding 1987) prefacing the research.

Rational approaches to the acquisition of social knowledge which informed the development of Utilitarianism and the formulation of the Social Contract (chapter 1) is characterised in the work of seventeenth and eighteenth philosopher such as Descartes, Spinoza and Leibnitz. The premises of rationalist approaches are that firstly, it is possible to obtain by reason alone knowledge of what exists; secondly that knowledge forms a single system that is deductive in character; and finally that everything in principle is explicable, since everything can be brought under

the single system. Thus pre-rational, pre-modern social knowledge in terms of super-natural determination imperceptible to ordinary humans was derided.

The problem with rational deduction is that it cannot engender any new knowledge: it is simply concerned to demonstrate what is there, implicit in its premises (Hume 1748). And with the growth of the empirical sciences the new inductive methodology of verification challenged the monopolism of rational deduction, now seen as unreliable as theories precede research and are thus unverifiable by any other observation. The rationalist approach was exposed as being as "meta-physical" or super-natural as pre-rational knowledge. The new empirical methodology provided knowledge of truth and falsity through observation and experience; and in enabling scientists to claim a "mind-independent" knowledge of reality, provided a means of questioning many of our 'ordinary' knowledge claims which were derived deductively. The eighteenth century identification of a 'private' realm informed by arbitrary, irrational principles was evidenced by such means

(chapter 1). Such an empirical methodology sought to avoid untested, theoretical speculation and thus to provide quantitative, directly observable evidence. Science, therefore, consisted in the systematic study of phenomena and the clarification of law-like relationships between phenomena.

However, the rationalist backlash to empiricism was that such methods can never be ultimately valid: they can never explain the processes that they identify, except in terms of the correlations of phenomena. The rationalist contention is that such correlations may be arbitrarily related: knowledge of what is true and false lies in the rational uncovering of the (real) underlying and often unobservable processes which causally relate phenomena, therefore requiring the deduction of valid conclusions from valid premises.

"Sociology" was defined by Comte in 1838 as a means of extending scientific positivism to the study of human nature and human needs. Its aim was to causally explain the regularities of human nature and needs in order to reorganise society

for the better¹. In particular, Comte was concerned to show the causal nature of individual motives and actions. Science provided predictions about individuals which then informed social actions, either to confirm or to avert the prediction, depending on whether or not the predicted event was regarded as socially desirable. Whilst the detail of Comte's project to reform society is now anachronistic, his scientific study of the functional contribution of individual actions to social institutions and continuity of social order provided the premises of contemporary organic explanations of society. Durkheim (1895) developed Comte's positivism to reject the individual level of social explanation as psychological, and thus false (chapter 5). Instead he posited that sociological method aims to investigate social facts, namely those phenomena that are external to the individual but yet constrain her actions in a real way. In particular, Durkheim was concerned with the causal nature of the social structure (chapter 5).

The conflict over the means and nature of knowledge raged, until Popper's "hypothetical-

deductive" method of scientific investigation (1959, 1963) attempted to define some democratic consensus². In his significant attempt to resolve the tension between rational and empirical approaches, he suggested that knowledge was to be gained through the principle of falsifiability, which required the testing and falsifying of hypotheses which are then replaced by new hypotheses also subject to testing and falsification. True knowledge of reality was to be ascertained when a tested hypothesis cannot be falsified. The deductive method is positively defended whilst making it amenable to empiricism. The problem, however, in attempting to bridge the antagonistic relationship between rationalism and empiricism lies in the antipathy between using empirical methods within a rationalist framework which is likely to account for scientist, in practice, working to defend their hypotheses by verification rather than refutation: science strives to maintain rather than to destroy its paradigms. The dilemma between reliability and validity remains: empiricism denied the possibility of ultimate validity; rationalism lacks reliability.

Sociological applications of Popper's principle of falsifiability entailed the self-conscious formulation of numeric or measurable properties which had "correlatives" in the perceptible world. This involved firstly the conceptualisation of what it is to be measured, leading to the definition of concepts; secondly to the specification of the dimensions of the concept and the selection of perceptible "indicators" of the concept; and finally the definition of "indices" or "practically operational concepts" (Lazarsfeld 1977). The sociological hypothesis is defined in terms of the relationships of "indices": the researcher works to clarify her theoretical perspectives with the aim to "operationalising" them in order to test them. The most reliable methods of testing, therefore, are those define operational concepts (variables) most clearly, such as the experiment of fixed choice questionnaires.

The problems with such a methodology, however, lie firstly in the assumption that what it is to be measured is conceptualised sufficiently precisely,

prior to the research itself, to enable an adequate consideration of each individual's possible relation to the concept under investigation (Cicourel 1964). This vast and inherently solip istic task assumes that, until the basic categories of everyday life are definitively clarified and quantified ("operationalised") social research cannot proceed. The positivist methodology of the falsification of hypothesis is thus necessarily invalid - with regard to human social life, at least (Cicourel 1964).

Secondly, the project of the identification and measurement of social phenomena presupposes a bounded network of shared meanings, and unless the 'rules' or 'language' of this network are made explicit the assignment of quantifiable values to social variables is impossible. However, the rationalist criticism is that the meanings of human relationships, or "networks" are unquantifiable renders this project not only inherently invalid, but also very likely to be unreliable insofar as social scientist themselves are members of social networks and thus that their

specification of reliable "operational" concepts will be in terms of their own particular 'network of common sense'. It is impossible to separate the scientific conceptual system off from common sense conceptual systems: the delineation of concepts which determine the form of measurement of a phenomenon is effected by the researcher's classification of her own experience, which is firstly (chronologically and experientially prior to her scientific training) common sensical. Furthermore, the measurement of social phenomena assumes that social scientific concepts are intertranslatable with perceptible common-sense concepts, in the active interaction of the researcher with the people who are being researched. To divorce scientific research from common sense understandings is to denude that research of any contextual, or even human significance: the realms of theorisation and the realms of data-collection and analysis overlap (Cicourel 1964) - they cannot be separated out into distinct (hierarchically related?) systems of concepts.

One way forward from this research impasse was to define "concepts" as the media through which we make 'sense' out of experience: concepts form the basis of incorporating image of reality into a shared meaning system, or "language" (Hughes 1976). Thus the process of "operationalisation" becomes characteristic of all human interaction: it is only in the "operationalisation" of experiences in terms of a shared language that experiences can be shared. However, there are problems for the empiricist here; since a concept is a relation between a symbol (ie a word) and an idea, and since relational concepts are not directly observable, then the link between a concept and the empirical world is only valid because some theory is assumed to be true. Furthermore, 'truth' becomes an interactive concept, and thus the empiricist imperative of reliability becomes an interactive concept insofar as it relies upon language (Denzin 1970).

Insofar as reliability is an interactive concept, all measurements of social phenomena can be assessed for their validity in terms of their ability to capture the emergent features of the

inductive process (Denzin 1970). Here the assumption is that greater inductive rigour will produce a closer approximation to the truth, thereby meeting the rationalist criticism of the intrinsic invalidity of inductive/empirical research. However, the criticism fails to be met insofar as such inductive approaches (invalidly) reduce relational concepts to discrete variables, however complex. Consequently, what is investigated is not the real nature of human society, but the observation that some social phenomena are perceived to have some regularity; and further, that in striving to clarify the interactional contingency of social investigations, the first principle remains true to the positive objective in establishing causal explanation, and thus theories of instrumentation remain the crucial lynch pin mediating theories/hypotheses with empirical/falsifying data.

Denzin (1970) contends that in order to achieve aetiological explanation a "triangulated" methodology must be used. This is analogous to Popper's conception of the hypothetico-deductive

method where he took the 'good' parts of both epistemologies and combined them in order to achieve a better perception of the truth.

"Triangulation" involves firstly the clarification and operationalisation of concepts. However, since no single form of measurement can sufficiently analyse all dimensions of a social concept, the most rigorous and reliable social research will use multiple methods. The vision is of a consensual plurality of methodologies, methods and researchers themselves, where the means of consensus is interaction of all parties. From this perspective, therefore, the reliability of a piece of social research lies in its interactional features, rather than in the isolation and presentation of particular variables in order to determine their "direction of influence"³ (Rosenberg 1977).

Within this perspective, therefore, the sociologist's reality can be seen as one of competing definitions, attitudes and personal values. Thus, the development of a "triangulated" methodology is more a statement of the culture of scientific inquiry (Hughes 1976) than a statement

of an 'objective' strategy. Denzin's (1970) "justificatory strategy" (Harding 1987) in developing a triangulated methodology is to achieve the most reliable knowledge; and, although he emphasises that methods cannot be regarded as competitive per se, the testing ground of empirical validation is certainly competitive in the race to achieve a greater and more universal 'truth'. Thus, despite the assumption that there is a single set of criteria through which the "methodological act" can be evaluated - namely the truth - in practice, although particular themes or ideas may be consistent with more than one epistemology, ultimately, by this analysis, there becomes a point beyond which disagreement must prevail.

From this perspective, then, sociology can never be seen as coherent body of knowledge: it can only be an arena of competing and unreconcilable paradigms - in this instance, of rationalist and empiricist paradigms. Social research is no more than a normative discipline, with the implication that there is no scientific reason to use scientific method. As there can be no absolute

criteria with which to assess the validity of sociological theories (Hughes 1976), this may, therefore be a cue to abandon method altogether. The only source of standards with which to judge sociological knowledge is the community of sociological scholars and practitioners; thus truth is not identified in its conformity with the real, but rather in its conformity with the criteria defining the scientific community (Phillips 1973).

The sociologist, therefore, is facing the same problematic as her 'subjects' - namely the process of making sense out of a social reality. Consequently social scientific concepts cannot be divorced from pragmatic or common sensical knowledge (Baldamus 1977): scientific knowledge must, therefore be seen as intrinsically related to every-day knowledge. Any changes in the nature of every-day knowledge are therefore crucially important to the development of scientific knowledge. The realisation of the dialectical relationship between scientific and every-day knowledge further problematises the principle that scientific advance (true knowledge) can only be

achieved through the hypothetical-deductive method of falsification. The interactive process between theorising and fact-finding, therefore, rather than being a steady continuous progression, may be conceived instead as a "discontinuous trial and error" (Baldamus 1977) process⁴. Since there is no real distinction between theory and fact, and since the underlying assumption is of historical discontinuity - or at least of the discontinuity of the occurrence of ideas - then the project to construct causal explanations of social actions is essentially misguided. The sociologists task, in this case, therefore is merely to observe and interpret the process (Winch 1958). This approach lends itself to an "anarchistic methodology" (Feyerabend 1970), such that sociology is regarded as a playful activity insofar as it is not guided by formal rules or methods, rather it becomes an end in itself. The context of social research is effected, therefore by "fancy, imagination and creativity", rather than any clear method.

The problem with this form of extreme methodological individualism is that it denies the possibility of any external validity: sociology is

simply one "form of life" among many in which 'truth' and 'reality' are entirely social constructs. Any underlying coherence is denied as science, sociology and common sense are all conceived as fragmented conceptual/linguistic games. This Wittgensteinian analysis dissolves both rational and empirical approaches to social research, rendering both comprehensible only within that distinct conceptual fragment. The correspondence between particular concepts and meaningful experience is impossible.

Despite the intrinsic solipsism of the analysis of social research as normative science, such an analysis is helpful in pointing to the significance of conceptions of the social world as a socially constructed linguistic and cognitive world (Smart 1976). Insofar as both rational and empirical science stress the importance of the causal analysis of human action, the social scientist is "free" to construct theories that are both external to and independent of the phenomenon under investigation: and thus intrinsically invalid. The clear recognition of the essentially social character of social research provides the

means of an understanding that attends to the meanings of human actions, and thus of the construction of social phenomena through meaning. Consequently, the positive identification of the reality of the world with human experience of the world cannot be a matter of "fact"; rather, the factual appearance of the world is due to our "externalising and objectifying practices" (Smart 1976). Insofar as this is the case, the task of the social researcher is to describe the processes through which the social world is constructed. This involves both considering the mode in which the natural world is experienced, and recognizing the inextricable linking of the natural with the social world in that experience. In particular, the social researcher must recognize the dependence of the social world upon the natural world for specific material resources necessary for its existence. It is this relationship of dependence that articulates the social with the natural world^o. Consequently an understanding of the social world involves more than the attention of methodological[✓] individualists[^] to the internal validity of social phenomena. Rather, it involves attention to the material conditions of our

natural or physical environment: in order to understand the processes of the construction of knowledge, it is necessary to attend to the social, economic and biological bases of that knowledge (Stacey 1988).

Traditional rationalist and empirical epistemologies both tend to mystify the dialectical relationship of material phenomena (bodily, economic) and the subject experience of these 'objects':

".. [sociology] incorporates as its topic the reified objectivism of laymen rather than the social practice which it hides. The conventional attitude is then reified into a language too obscure for laymen to understand. The second level reification thus transforms a commonplace commodity mystification of social life into a neutral science of the manipulation and management of social life." (Horton 1971, pp176-177).

The whole project of social research is problematised. The development of interactive methodologies in response to the tension between the rational validity and empirical reliability led to methodological innovation in an attempt to develop a more liberative sociology. Such innovations, however, have their roots in an epistemology that either objectifies social life,

or else begins to dissolve into solipcism. The contemporary concern to develop a

".. modern 'value-free' sociology is the anomic adaption of sociological positivism to political failure, an adaption that commonly takes a ritualistic form, in which pure knowledge or the methodology of map-making tends to become an end in itself... .. 'objectivity' is not neutrality, but an alienation from self and society.. [it] is the ideology of those who reject both the conventional and alternative mappings of the social order.. [however these] 'objective' men, even if politically objective, are middle class and operate within the boundaries of the status quo." (Gouldner 1971, p102-103).

Gouldner (1971) points to the relationship between the material/economic position of sociologists and the development of their theories: despite the utilitarian (chapter 1) and egalitarian professions of the interactive sociologists, their epistemological limitations prevent any liberative action resulting from their research (chapter 5). Insofar as the "justificatory strategies" (Harding 1987) of liberal sociologists are not only tied epistemologically to objectified premises, but also to their professional status through their membership of the community of academics, the implications of their research are confined within the parameters of the "status quo". Liberal, or interactive sociology goes some way towards

attempting to resolve the tension between epistemologies stressing reliability and those stressing validity, however they failed to effect the means by which information is gathered and the presentation of data (Keibler & Light 1979). Specifically, although they did effect some methodological change - in terms of "triangulation" (Denzin 1970) and the development of a consensual approach including both research methods, researcher and research subjects - by failing to problematise the normative determination of social science epistemology they didn't go far enough.

The methodological problems encountered by the empirical challenge to rationalist epistemologies shook the foundations of empiricist epistemology insofar as they returned time and again to deductive premises, leaving the way open for the spectres of idealism and nominalism. The way out of the epistemological impasse, therefore, was not in the institution of consensus and the practice of a plurality of methods; rather a "paradigm shift" (Kuhn) was required. This emerged in the critical recognition of the reflexive relationship

not only between epistemology, methodology and method, but also between research approach (defined in the reflexive relationship between epistemology, methodology and method) and social practice: the relationship between theory and practice - "praxis". Such a recognition implied that all knowledge is 'interested' knowledge. And thus, such a recognition provided the possibility for the development of a de-mystified knowledge, firmly grounded in material experience.

At this point some consideration of how academic concepts are actually defined, related to one another and used in normal science is possible (Spender 1978). This critical project provides the possibility for the development of new criteria of what counts as knowledge.

"Under patriarchy, Method has wiped out women's questions so totally that even women have not been able to hear and formulate our own questions to meet our own experiences. Women have been unable even to experience our own experience." (Daly 1973, p12).

In recognizing that "it commonly happens that the choice of a problem is determined by method, instead of method being determined by the problem" (Daly 1973) it becomes clear that to follow the imperatives of normative method is to uncritically

accept justificatory strategies without ascertaining their suitability for the investigation in question (Westkott 1983). Such a critical approach requires the social researcher to judge what it is that she is observing: to deny the power of 'seeing' as judgement is regarded as

".. diluting the power of 'seeing' so that it becomes an enfeebled process of blind observation and bland description." (Westkott 1983).

To separate the phenomena of 'seeing' (or observation) from the phenomena of judging is thus regarded as abstracting it from the context of human understanding, and thus to denigrate judgement to mere 'opinion'.

The issue of "judgement" indicates the significance not only of the cultural context of social research, but also of the general context of human understanding. By this analysis, therefore, neither social research nor human understanding can be "value-free". Gouldner (1971) suggests that "scientific" method" is more than simply a logic, rather it is a morality.

Consequently, the first step in developing a methodology appropriate to women's knowledge and experience is to specify the underlying morality

of conventional approaches which prohibits the development of our understanding of women's experiences. And on the basis of this critique, an alternative strategy may be built.

One critique of the implicit morality of scientific epistemologies distinguishes between those characterised by "agency" and those characterised by "communion" (Carlson 1971, 1972). Carlson (1971, 1972) was concerned to clarify the recurrent polarity in social science research between methodologies stressing reliability (using statistical methods, for example) and those which stress validity (making use of the case study approach for example). Carlson (1971, 1972) classified research that is concerned to measure "variables" such as sex, as "agentic" research. She characterised such methodologies as involving "separation, mastery and control". Research that is concerned with human beings as people rather than clusters of variable, alternatively is classified as "communal"; and characterised as involving "fusion, expression, acceptance, non-contractual co-operation". Furthermore, "communal" research methods entail "naturalistic sensitivity,

sensitivity to qualitative patterning and greater personal participation by the investigator", valuing the lack of overall control of the investigator. Carlson (1971) concluded that men prefer to use "agentic" research methods, producing "hard" results; whilst women prefer "communal" methods, typically producing "soft" results.

However, Carlson (1972) maintains the means of constructing social reality through sets of interlinked polarities, such as objectivity/subjectivity, reason/emotion, reality/phantasy, hard data/soft data etc, rather than a radical transcendence of bifurcated conceptions of reality. Bernard (1973) suggests that a more effective critique of conventional methodology recognize that such dichotomous thinking is intrinsically related to the gendered bifurcation of the social world; and from this point to achieve an "androgynous" methodology. Such an approach, however, translates the adoption of a "triangulated" approach (Denzin 1970), characteristic of liberal social research into 'anti-sexist' terms. Not only do the elements of

the newly 'consensual' approach retain their distinct identities (for example, the 'survey method' is "triangulated" with 'participant observation' to fuse "agentic" with "communal" approaches in an "androgynous" manner); but the epistemologies which form the foundation of each method remain intact. And, as I noted above, although in practice any one set of themes or ideas may be consistent with more than one set of epistemologies, ultimately there is a point at which disagreement must prevail. To moot a Kuhnian principle, we cannot simply take all the various research concerning women from all its sources and "fuse" it, expecting it to be coherent: knowledge is not something that is simply cumulative or coherent.

"Our data will not arrange themselves."
(Coyner 1983, p57).

And this being the case, any development of new knowledge must necessarily involve the judgement of old knowledge as the means to an alternative "justificatory strategy" for the new knowledge. Thus the development of a feminist epistemology cannot be resolved by simply integrating a variety of methods with an honourable intention to avoid sexism. Methods cannot be severed from their

reasons for existence (epistemologies), which must necessarily express a particular, interested view of reality/truth.

The starting point for science/knowledge, therefore is in the posing of meaningful questions or problems, and then:

".. what is scientific in method is to address that question in the manner and terms most consonant with its substance, and most likely to lead to relevant answers." (Du Bois 1983, p109).

Scientific method, therefore is defined in the questions that are asked, which, in turn, are defined in terms of their social/scientific context. The 'knowledge', therefore, derived from such science, is more about the values of the scientific community than about any definitive reality or truth (Hughes 1976): scientific method is a morality (Gouldner 1971). Science/knowledge, therefore may be "fundamentally flawed" (Du Bois 1983) insofar as it renders women unknowable even to ourselves (Daly 1973). The 'person' - the subject of social research - is conventionally taken to be male; and thus women have been defined in social research in terms of what they are not, rather than in terms of what they are. 'Woman', as

'not-a-man' is thus rendered intrinsically unknowable, lacking a scientific identity.

"'Naming' is probably the first order of interpretation in science... In science, as in society, the power of naming is at least two-fold: naming defines the quality and value of that which is named - and it also denies reality and value to that which is never named, never uttered." (Du Bois 1983, p108).

And despite the contemporary rash of feminist scholarship, we may still be in the processes of doing "feminist archaeology" (Du Bois 1983): still in the process of seeing and judging, of clarifying our initial research questions.

Furthermore, since

".. the most important task of thinking [is to] reinterpret knowledge in terms of experience.." (Rich 1977 pxxiii)

it is important to rigorously describe the realities of our experience - "reality-without-explanation" - before moving onto developing a "truly grounded theory about women". And, since "feminist archaeology" is a communal task, it must involve a

".. community of women .. [who] advance and foster both attempts at knowledge and a personal conviction about the content and methods of getting knowledge. It creates a new sense of connection between knowledge, work and personal life." (Miller 1973, p136).

The development of a feminist epistemology must, therefore, involve our opening-up and sharing our

methods in order that our knowledge is accessible:
"the knower and the known are of the same
universe; they are not separable". Science which
"pretends to leave the self" in its quest for an
objective reality/truth cannot provide an adequate
knowledge.

"Our science-making, rooted in, animated by
and expressive of our values, empowered by
community, is *passionate scholarship*,
necessary heresy." (Du Bois 1983, p112, her
emphasis).

Feminist consciousness, therefore, must form the
basis of epistemologies that provide the means of
knowing women. This involves more than simply
identifying some sorts of methods, generally
qualitative as 'feminist', and others, generally,
quantitative, as 'sexist' (Stanley & Wise 1983).
Feminist consciousness involves "seeing reality
differently", and informs the development of a
methodology that takes the "research-experience"
as any other experience; and further that the
researchers experience and consciousness is
central to the research process (Stanley & Wise
1983). Thus the critique of the separation of
objectivity from subjectivity which points out
that humanity is abstracted from knowledge is
applied to feminist research in the recognition

that such dichotomous epistemologies provide for the exclusion of women from knowledge.

"... 'objectivity' is the term men have given to their own subjectivity." (Rich 1979).

In order to achieve some knowledge of women, women must become centrally involved in the research process not only as 'subjects' but as active researchers.

Stanley & Wise (1983) criticise "normal scientific method" as a means of re-constructing a particular, objectified form of social reality - a sanitised account, constructed to fit-in to the accepted rules of the presentation of research. Traditional positivist methodologies and more recently developed interactive methodologies construct objectified and sanitised forms of knowledge insofar as their justificatory strategy/epistemology structures the way in which descriptions and accounts are presented (Stanley & Wise 1983, Cicourel 1964). A key issue here is power. Namely the maintenance of an epistemological hegemony through the methodological principle of the distance between the researcher and the researchee. Non-feminist methods - whether traditional or interactive -

empower the researcher to define what 'counts as' "data", and further to interpret that data with the context of his epistemology. Social research accounts, therefore are pre-structured in a "logico-temporal manner" (Stanley & Wise 1983), such that they provide information merely about the logical development of an argument, rather than the temporal occurrence of social events during the research process. In order to produce a 'truly valid' piece of research that is "true to the phenomenon", Stanley & Wise (1983) contend that the "phenomena" - people - must present their own analytic accounts of their own experiences. The researcher role is to present analytic accounts of why and how we think we know about research situations and the people in them. In this way, the research may lead to a knowledge of the "logic-in-use" of people.

".. theory should be pragmatic, practical and every-day. It should be a set of understandings or conceptual frameworks which are directly related to, or derive from, particular facets of everyday relationships, experiences and behaviours." (Stanley & Wise 1983).

Stanley & Wise (1983) thus advocate an ethnomethodological approach, informed by a feminist consciousness. They suggest that methods

per se cannot be regarded as sexist; rather that it is the intent of those who use the methods that makes research sexist. This assumes the deductivist principle that theory (consciousness) precedes and thus structures research: their notion that "untainted" or 'pure' knowledge may be achieved through essentially "androgynous" methods (Bernard 1973) applied through feminist consciousness must retain the elements of the epistemologies informing the development of such methods (Cicourel 1964).

The development of a research project within the context of a specific methodological approach is not enough, therefore, to examine the processes involved in the construction of knowledge that excludes women. Women's concerns about conventional methodologies are

".. not .. intrapsychic, personal problem[s], but derive from structural inconsistencies and skewed assumptions underpinning the methods themselves." (Reinharz 1983, p166).

To simply apply a feminist consciousness to an internally "skewed" method further mystifies knowledge in dealing only with the internal validity of the research process. The way forward in developing a knowledge of women is not, then to

develop a sort of liberal consensus based on the assumption of the intrinsically "androgynous" nature of research methodologies. Both positivist and interactive approaches assume to importance and autonomy of the individual (whether researcher or researchee) as a discrete/discreet unit which

".. possesses certain rights independent of the state and anterior to its very existence...

Where [positivist methodologies] inflict on [atomised individual] the mechanical emptiness of psychometric testing - ignoring or denying their sociocultural context - [interactive methodologies] typically celebrate the uniqueness of the individual person and his or her personal growth and self-actualisation either in opposition to an oppressive society from which he or she could potentially achieve liberation, or, sometimes, with little mention of sociocultural context at all." (Kitzinger 1987, p35-37).

The problem, therefore, with Stanley & Wise's (1983) approach is their emphasis on the researchers consciousness (despite their clear intention to develop a feminist method based on social action rather than on a psychology of inner thoughts) which lends them to a liberalist analysis lacking a clear consideration of the issue of the differential power of the researcher and researchee to articulate their *individual* experiences.

The processes of the construction of knowledge involve more, therefore than the identification of specific research methods and the individual consciousness of the researcher. A broader perspective would consider the implications of social (rather than merely methodological) divisions where

".. some skills and competencies are more highly regarded and carry higher status than others." (McRobbie 1982)

Furthermore, such divisions provide some individuals with

".. the privilege of stating; those who write, those who discuss publically and make pronouncements." (McRobbie 1982)

Consequently, insofar as the social research process is defined in "stating", in publically available written discussion concerned with "making pronouncements" the feminist researcher following Stanley & Wise's (1983) proposals will experience

"The tension arising between the anarchy and all pervasiveness of talk and the order and formality of written words." (McRobbie 1982).

The researcher in her quest for valid, unsanitised accounts of social life is faced with the issue of the translation of the every-day verbal flow of ideas and analyses into a publically available

form. McRobbie (1982) points out that the difference between "talk", denigrated as "gossip", and "text" as an intense and essentially privatised activity reflects the hierarchical tensions in the social division of women and men, researchers and researchees. She suggests that the only way to overcome the problem of the translation of talk into text is to actively recognize the interdependence of both parties - the "dialectic of talk and text"; and to recognize that research, as a social enterprise, involves relations of production. As such, the process of the production of social research is clearly political, involving a division of labour and social relations of production (Morgan 1981).

A recognition of the "sociological mode of production" (Morgan 1981) provides the means for avoiding the liberal seductiveness of Stanley & Wise's (1983) methodological individualism. In their concern with the valid presentation of data, their emphasis on 'consciousness' includes any feelings of self-awareness, without any critique of the construction of the "self" that this involves. Smith (1977), however provides an

analysis of the sociological mode of production that facilitates the development of a "feminist standpoint" as the means of knowledge of women.

Smith (1977) contends that

".. there is an unfortunate fit between men's characteristic understandings of social life, sociology's favoured conceptual schemes, and the kinds of knowledge needed for 'ruling others'" (Smith 1977, p84).

And thus identifies sociology as part of the practices through which we are governed: since governing is through concepts and symbols, and since sociology "works up" the conceptual procedures, models and methods by which the immediate and concrete aspects of experience can be "read into the conceptual mode in which the governing is done", sociology must be identified as an administrative activity in which the actualities of what people do are transmogrified into the "conceptual currency" in which it can be governed. In this way, then, sociology is about the administrative construction of living issues into discrete phenomena: issues are constituted as *problems in relation to the actual practice of government*. Thus social experience is transformed into categories of, for example, mental illness or

crime, thereby achieving a "conceptual currency" through which it can be managed.

This analysis immediately begins to provide some substance to the issues of reliability and validity that concern social research: the justificatory strategy of all social science may simply be defined as control. McRobbie (1982) focuses the issue of control in discussing modes of communication: "text" provides the basis for the "conceptual currency" of government, translating the anarchic possibilities of everyday life into administrative 'problems'. As sociologists, we learn the 'sociological' mode of analysis, which in accordance with the administrative nature of sociology, requires the "sociological subsumption" of the actualities of ourselves and of other people: that we treat the world as instances of the sociological body of knowledge (Smith 1977). Sociological education, therefore, works as a sort of conceptual imperialism.

A major aspect of sociological hegemony is the ethic of 'objectivity'. This is primarily concerned with the

".. separation of the knower from what he knows, and in particular with the separation of what is known from any interests, 'biases' etc, which . are not in the interests of the discipline." (Smith 1977, p88).

Consequently, what we think or feel about society must be taken apart and kept separate from what we are professionally interested in:

"[The sociologist] passes beyond the particular and immediate setting in which he is always located in the body (the office he writes in, the libraries he consults, the streets he travels, the home he returns to) without any sense of having made a transition. He works in the same medium as he studies.

But like every one else he also exists in the body in the place in which it is... it has to happen here if he is to experience it at all... he uses what becomes present to him in this place as a means to pass beyond it to the conceptual order... it establishes two modes of knowing and experiencing and doing, one located in the body and the space which it occupies, the other which passes beyond it. Sociology is written in and aims at this second mode." (Smith 1977, p88-89).

Inherent in all social research, therefore, there is a "bifurcation of consciousness":

"Sociology can liberate the mind from time and space themselves and remove it to a new and transcendental realm where it no longer depends upon these Aristotlean categories." (Bierstedt 1966).

This sociological "bifurcation of consciousness" depends upon an essential alienation of "man from his bodily and local existence": the sociologist must be "liberated" from his bodily existence with all its demands and impulses. This "liberation", however, requires that *someone else* will care and attend to the bodies of administrators/
/sociologists. And, as women remain outside and subservient to the sociological conceptual structure through their firm anchoring in the local and particular (Hartsock 1987), women provide the means through which men can become sociologically "liberated" from space and time. And further,

"The more successful women are in mediating the world of concrete particulars so that men do not have to become engaged with (and therefore conscious of) that world as a condition of their abstract activities, the more complete men's absorption in it, the more effective the authority of that world and the more total women's subservience to it."
(Smith 1977, p90).

And as sociological concepts and methods are organised around and built up out of a way of knowing the world which takes for granted the boundaries of an experience of the same medium in which it is constituted, sociology is incapable of questioning the conditions of its own existence.

"[Sociology] is not capable of analysing its own relation to its conditions because the sociologist as an actual person in an actual concrete setting has been cancelled in the procedures which objectify and separate him from his knowledge. Thus the linkage which points back to its conditions is lacking." (Smith 1977, p90).

In this analysis, then, women sociologists must, therefore, experience a continuous "bifurcation of consciousness": as sociologist we must "liberate" ourselves from space and time, from the everyday concrete and particular experience of living in our bodies; and as women we live in a world effected by our bodies.

".. even before we become conscious of our sex as the basis of an exclusion .. we nonetheless do not fully enter ourselves as the subjects of its statements since we must suspend our sex, suspend our knowledge of who we are as well as who it is that is in fact speaking and of whom. Therefore we do not fully participate in the declarations and formulations of its mode of consciousness. The externalisation of sociology as a profession .. becomes for women a double estrangement." (Smith 1977, p91).

From this analysis, Smith (1977) contends that women's perspective provides the means to discredit sociology's claim to objectivity. It may also reveal the organisation and conceptual procedure, methods and relevancies from an "determinant position in society". And this "critical disclosure" of the underlying logic of

sociology may then form the basis of an alternative "way of thinking sociology":

"If sociology cannot avoid being situated, the sociology should take that as its beginning and build it into its methodological and theoretical strategies." (Smith 1977, p91).

Sociology may be reorganised in order that the relationship of the sociologist to both the object of her knowledge and her problematic is transformed. This firstly involves placing the sociologist where she is situated, namely at the beginning of those acts by which she knows or comes to know; and secondly, making her direct experience of the everyday world the primary ground of her knowledge. The methodology aims firstly to make socially organised properties observable, and then to make them problematic - thereby developing a reflexive sociology that is not aimed primarily at itself.

A key element in Smith's (1977) argument is her distinction between 'experience' and 'perspective'. In her emphasis that

".. to begin from direct experience and to return to it as a constraint or 'test' of a systematic knowledge is to begin from where we are located bodily." (Smith 1977, p92).

Smith (1977) is careful to stress that she is not using the term 'experience' as a synonym for 'perspective': she is anxious to avoid any

".. enterprise.. with the self as sole focus and object... Such subjectivist interpretations of 'experience' are themselves an aspect of that organisation of consciousness which bifurcates it and transports us into mind country while stashing away the concrete conditions and practices upon which it depends." (Smith 1977, p92).

It is this rigorous materialism that distinguishes Smith's approach from that of Stanley & Wise (1983). In beginning their methodological approach with the "double consciousness" of the woman researcher, they left the "bifurcated consciousness" of sociology itself intact. Consequently, Stanley & Wise (1983) imply that social scientific concepts can have no correspondence with meaningful existence: they must be analysed as one form of subjugated knowledge among many. Feminist social science, therefore, by this analysis, can only consist in the accounts of many different women's experiences/knowledges.

Smith (1977), however, develops her methodology from an explication of the tacit epistemological

bases of social research to an "exploration through that of what passes beyond it and is deeply implicated in how it is". Thus

"Our conceptual procedures should be capable of explicating and analysing the properties of [the] experienced world rather than administering it." (Smith 1977, p93).

Smith's (1977) epistemology is based on the

".. contention that there are some perspectives on society from which, however, well intentioned on may be, the real relations of humans with each other and the natural world are not visible." (Hartsock 1987, p159).

She is asserting that there is an underlying 'reality' which is not immediately evident, and which 'science' as a particular method of achieving knowledge provides the means of analysis. The basis and 'control' of this 'science' must be experience, which is defined through our "bodily location". Smith (1977) contends that women's experience is more complete and less distorting than men's experience, and thus she argues for "women's perspective as a radical critique of sociology".

In developing the "justificatory strategy" for my own research project, I took my cue from Smith (1977). In recognizing firstly the "double consciousness" of women, and secondly the "sociological bifurcation of consciousness" I hoped to deal with both my experiences as a woman "in and of society, but in important ways also 'not' of it" (Du Bois 1983), and my experience as a sociologist in investigating drunken women. My selection of 'drunken women' as the focus of my research stands upon my experience of my drunken mother, who not only was "not of society" as a woman, but also as a deviant. In researching the literature on inabstinent women and in actively engaging with sociologically defined "drunken women", apart from my mother, I became more aware of the inchoate potential of women's experience as a "radical critique of society".

"..women's inhabit our world with a double consciousness .. [since] we are in and of our society but in important ways also 'not' of it. We see and think in terms of our culture; we have been trained in these terms, shaped to them; they have determined not only the ways in which we have been able to perceive and understand large events, but even the ways in which we have been able to perceive, structure and understand our most intimate experiencing. Yet we have always another consciousness, an other potential language within us, available to us. We are aware, however inchoately, of the reality or our own

perceptions and experiences; we are aware that this reality has often been not only unnamed but unnamable; we understand that our invisibility and silence hold the germs of both madness and power, of both dissolution and creation." (Du Bois 1983, p112).

Through my research I came to understand how all women may be 'drunk', in a material sense, insofar as they are constructed through dependency. The "sociological bifurcation of consciousness" became evident to me early in my literary research, as I encountered both the paucity of material (Annis & Liban 1980) on drunken women, and the level of abstraction of the analysis of drunken women. My own experience as a woman who drinks and as a woman with a sociologically defined drunken mother had no place in the literature with the exception of one or two instances. Drunken, drinking and generally inabstinent women had no place in the academic analysis and description of drinking and drunkenness: they remained "non-descript", and thus, to some extent, 'free' from the processes of sociological and administrative control (Worrall 1990) (Chapter 5).

Sociology, therefore, can be seen as a key aspect of the social processes which control women: the actualities of women's lives are transformed into

a "conceptual currency" through which they are governed. Inabstinent women remain invisible in that "currency", disguised as merely 'mad' or 'bad', rather than actively monstrous. And in their administrative classification as 'mad' or 'bad' the management of such monstrously unabstinent women is reinforced, amplified (chapter 5) and lacking an active name, they are domesticated.

Furthermore, my emotional, "passionate" (Du Bois 1983), engagement with the literature as well as with drunken women themselves was definitively contrary to my sociological training. Sociology required the transcendence of passions, especially as they are defined through the body, and as my engagement with my 'material' was defined through my experience as a woman, it remained below (beyond?) sociological consideration. My "sociological bifurcation" was most acute in my concern to avoid replicating and/or reinforcing the administrative control of women through the imperialist conceptual currency of sociology in transmogrifying social phenomena into social 'problems', necessitating intervention. I hope

that I have, by and large, succeeded in this in laying bare the assumptions of such "conceptual currencies". In my literary research, my primary concern was to explicate the social control of women through the construction of 'femininity' at the interstices of psychiatric, psychological and sociological/functionalist discourses or "conceptual currencies". I hope that I have indicated that concepts such as rationality, liberalism, objectivity assume the status of "universal equivalents" within these discourses of the construction of femininity and the control of women: that these discourses and universal equivalents are a key means of the administrative control of women through sociology and social science in general.

In my engagement with drunken women, and workers concerned with drunken women, I attempted to relate the sociological/administrative control of women evident in the literature to drunken women's actual experience of social control. Firstly, I was concerned to indicate the influence of the social scientific discourses of social control in workers perceptions of drunken women; and

secondly, I wanted to listen to socially defined drunken women's perspectives of their drunkenness and their 'administration' (or 'treatment') by health and welfare agents.

My field-work occurred in three stages: firstly a postal survey of alcohol-related 'welfare' agencies in Glasgow; secondly semi-structured interviews with a sample of agency workers; and finally group discussions and semi-structured interviews with women administratively defined as "drunken"/"alcoholic".

The first stage of my field-work took the form of a postal survey (1986) of all agencies believed to have some provision for drunken women in Glasgow^a. In total 48 agencies were sent questionnaires (appendix 1), and I received responses from 46. Eight of the 46 responding agencies dealt exclusively with men, and I excluded these from further consideration leaving a total of 38 respondents. Of the 38 remaining agencies, 16 provided services specifically for women, although of those who did not have any specific facility for women, 4 had plans to develop such provision

(Appendix 3, table 2a). 18 agencies felt that there was a need to provide alcohol services specifically for women (Appendix 3, table 2d), in particular women-only groups, residential facilities and refuges for women with children (Appendix 3, Table 2e). Most agencies, however, (35) had women staff available for women clients/patients on demand (Appendix 3, table 2b); and most agencies included between 41% and 70% women staff (Appendix 3, Table 2c).

In general, the main types of service provided for drug and alcohol-related-problems were educational and counselling (appendix 3, tables 1a & 1b). Clients/patients appeared at the agencies surveyed through a variety of channels, primarily statutory health and social services, although self-referrals and referrals through intimates also featured strongly (Appendix 3, Table 3a). Agencies referred clients/patients on to a number of other agencies, although again the statutory health and social services featured strongly; also with a strong rate of referral on to the non-statutory/voluntary Councils on Alcohol and Alcoholics Anonymous (Appendix 3, Table 3b).

This preliminary investigation indicated a high degree of involvement of the statutory health and social services in the provision of alcohol-related-services. Furthermore, 'treatment' was primarily focused at the individual, in the form of counselling and/or educational work. Almost half the agencies surveyed saw the need for specific women's services.

The second stage of my field-work took the form of semi-structured interviews (Appendix 4) with a sample of agency workers. My sample comprised all those who felt that some specific provision should be available to women, and included 20 workers (Appendix 5, Table 1). Of these agencies, the main treatment focus of 11 was advise and counselling (Appendix 5, Table 2); Seven of these agencies were non-statutory, the remaining 4 being statutory, although all fell within the social (rather than health) services, and 2 were reliant on Urban Aid funding. Five of the workers that I interviewed were located residential agencies, all of these were non-statutory. Four remaining agencies were National Health Service Agencies,

and two provided worker support and training and general services co-Ordination - one being statutory, the other non-statutory.

I discuss my findings in detail in Chapters 7 and 8. Although at this point I should make the point that one confounding factor in the selection of my sample of agency workers was that the person who completed and returned the preliminary postal questionnaire was not always the same person that I interviewed. Nevertheless, I always felt welcome, and was impressed with the time that the workers made available to answer my questions. I asked all the workers that I interviewed permission to tape-record our discussion in addition to making written notes. Most workers agreed; the quality of the recording and the success of my subsequent transcription varied considerably!

At this stage, I asked one worker from a statutory health service agency, one from a statutory social services agency, one from a voluntary Council on Alcohol, and one from a residential Church of

Scotland agency if I could meet with a group of their women clients (Appendix 5, Tables 6 & 7). All except one agency had women's groups running at the time of my research, and all agreed that they would ask the women in their groups if I could meet with them. The agency which didn't have a women's group was the statutory health service one - Gartnavel Royal Hospital Alcohol Treatment Unit; the worker referred me to the Charing Cross Clinic which provided out-patient services, including a women's group for Gartnavel Royal patients. The Gartnavel worker, however, did offer to ask some of the women patients if they would meet with me individually.

The third stage of my field-work, therefore, involved group discussions with women defined as "alcoholics"/"problem drinkers" in four locations (Appendix 5, Table 6). Firstly, Parkhead Alcohol Advise and Information Centre: this was a statutory social services agency (although it was also reliant upon Urban Aid funding) which provided advisory and counselling services. I met with five women here on three occasions. Secondly, Charing Cross Clinic: this was a National Health

Service out-patient facility. I met with 8 women here on three occasions. Thirdly, Renfrew District Council on Alcohol: this was a voluntary agency, providing advisory and counselling services. I met with 4 women here on two occasions. And finally, Westercraigs Alcohol Problems Resource Centre: this was a Church of Scotland residential agency. I met with 7 women here on three occasions.

In all four agencies I was affected by the openness of all the women concerned. In all cases, the worker remained with the groups on the first occasion. This first meeting was usually fairly formal, taking the form of a semi-structured 'round-table discussion' (Appendix 4). After the ice was broken, however, in subsequent occasions, I tended to meet with the women in drinking coffee or tea, smoking and generally discussing drunkenness. I took written notes during my discussions with the women when it was appropriate, and wrote up my impressions of our discussions when I got home.

I felt that it was important, at this stage, to stress my reasons for researching drunken women. I

had discussed this with the workers, but sharing, to some extent, a reliance upon textual information in our professional capacities, much was left implicit, assumed. With the women, however, I was concerned to avoid exploiting their honesty and open acceptance of me, and went to some pains to clarify the confidentiality of my research. Here, my personal reasons for investigating drunken women became evident: I always mentioned my relationship with my mother, and sometimes discussed my voluntary work with women, some of whom experienced drunkenness problems. And as I got to know the women over the course of two or three visits, some would ask me increasingly pointed questions about my personal involvement with drunkenness. I always answered such questions (indeed all questions) honestly; and I learned to experience my mother slightly differently through such discussions.

Finally, I asked the workers in these four agencies if I could meet with women who I had not already met, to talk individually about drinking and drunkenness. Again I was met with a very positive response, all four agencies agreed to ask

their women clients/patients if they would see me; and women from three agencies agreed. Unfortunately no woman from Renfrew District Council on Alcohol wanted to see me. Consequently, I saw a total of nine women individually: two from Parkhead, 2 from the Charing Cross Clinic, three from Gartnavel Royal Alcohol Treatment Unit (in-patients), and two from Westercraigs. I spent anything from half an hour to four hours with each woman, and again I was much affected by their confidence and trust. I asked most of the women I spoke to individually if I could tape-record our discussions in addition to making written notes; if a woman seemed nervous in any way, however, I left the tape recorder in my bag switched firmly off. I recorded my conversations with six of the nine women who I saw individually, and as with the workers, the quality of the recording varied tremendously, and thus the length of my subsequent transcription. I relied, heavily, therefore, on my notes written during my discussions, and my observations as they were written up following my meetings.

My field-work work was conducted on a small-scale basis, and cannot be considered "reliable", "replicable" research in any way. It's strength, however, lies in the quality of detail that I was provided with in my reception from the women and the agency workers that I spoke with. I believe that the wealth of qualitative detail was facilitated greatly through my openness in both the nature of my research project and my personal involvement with drunken women. Although my research necessarily involves some degree of interpretation of my discussions with workers and drunken women, I have made use of extensive quotation in order that their voices may be heard. My standpoint in 'ordering' my transcriptions, however was clear from the outset to all the people with whom I spoke, and is clear in my written representation of those discussions.

CHAPTER 7:

WOMEN DRINKING

My first research interest was in the processes and experiences through which women come to be 'alcoholic'/'problem drinkers'. In meeting with such women and with drug and alcohol agency workers, I discussed this issue with all parties, and gradually built up a picture of the social processes effecting women's drinking. With regard to the agency workers, I was immediately struck by the significance of gender on their perceptions of women's drinking and drunkenness. Of the 20 workers whom I spoke to, out of 11 men, eight held explicit organic/functionalist views of women's drinking, such that drunken women essentially more pathological and more obdurate than men, and that "alcoholism is the ransom of emancipation" (Appendix 6, Table 1); only 2 out of 9 women held such views. Alternatively, women were far more likely to express a more radical perspective on women's drinking (8 out of 9 interviewees), feeling that processes of the social control of women, such as domestic isolation and the

intervention of health and welfare agents (such as themselves) accounted for most of the drunken women they encountered in their professional capacity (Appendix 6, Table 1).

Most of the women administratively defined as 'alcoholic'/'problem drinkers' similarly felt that women drank more to cope with the enforcement of their social isolation, than as an expression of their liberation: most of them were painfully aware of the risk of sexual/physical violence/damage through their drinking, and related this to issues of the social control of women (Appendix 6, Table 2c). Furthermore, the women I spoke to were also clearly aware of the role of health and welfare agents in controlling their activities, 1 in terms of their roles as mothers. Some clearly resented this, and actively rebelled by continuing to drink whilst attending the prescribed treatment programme; however, most were effectively compelled to remain abstinent in order to maintain custody or access to their children. The one woman (Rose) who had never had children or been married was clearly "non-descript" (Worrall 1990) in her failure to 'fit' the administrative categories of

health and welfare agents: she was unequivocal in her persistence in drinking through her 'treatment', whilst simultaneously recognizing her subjection to a significant degree of sexual and physical violence. She did, however, express her liking for her agency workers, who were women, and who provided some level of political/enabling support. In this both Rose and her workers were unusual as the organic/functionalist analogy was evident in the workers perceptions of causes of drinking problems in women. Many workers (7)¹ felt that the contemporary equal opportunities movement exposed women to a greater risk of developing alcohol problems insofar as it neglected women's 'essential nature'. Drunken women were perceived as inherently different and more pathological than men (10):

"I think there's a fairly strong hysterical inclination in a lot of women-folk who have an addiction problem. In other words, it's not only a dependency on a chemical, but very often there's .. an abnormal dependency on people also - and a certain hysterical attachment because of that and therefore we need to be careful because very often the kind of person who has had that kind of hysterical attachment also has a proneness. I wouldn't put it any weightier than that - a proneness towards a kind of blackmailing in their personality. You find different things with men..." (male worker).

"I think it's very much a problem of sexual immaturity - get themselves pregnant and have kids." (male worker)

"Women have problems in that they're very emotionally involved - especially when it's their children... Extremely sorry for themselves and the damage that they're doing to their bodies/families." (male worker)

"Where would you like me to start? They seem to have a lot more problems with their spouse and with their family than men do. Personally I think they've a lot more emotional problems than the men do - they tend to worry a lot more than men do, about their children. I tend, well my personal opinion is that you tend to find a lot of women quite depressed, we've had a lot of neurosis coming in, maybe not so much neurosis as depression, worrying about things - more so than men." (male worker)

This belief in drunken women's greater psychiatric pathology implies that they are more obdurate than drunken men (2):

"It's harder to work with drunk women than with drunk men - women are so demanding - oh really bitchy and resentment, hate and whatever you call it - personal jealousy - women that men'll go to don't say nothing until they get a drink. They cannae communicate, but see when all the booze comes out then all the hate comes out - and you get it. Because men can get it out anyway - if a man's aggravated he'll tell you he's aggravated or else he'll thump you - where a woman can't do that." (male worker)

The implication of this organic/essential difference between women and men is that the institution of social equality will exacerbate the problem. Women's difference is seen as a

protection from drunkenness and alcohol problems

(6):

"Women're less likely to develop drinking problems - it's a good thing not a bad thing. I mean everybody sort of puts it the other way around, thinking women and drunk is terrible. Women provide a model of safe drinking. Sex is important - it's protection - it's not a vulnerability. Antisocial, criminal activity, that's very unusual for women, not unknown, but unusual for women - which is good. But then I suppose that reflects that women are not as violent or aggressive in the general population."
(female worker).

"I think women're more stigmatised than men and that's to do with drinking or heavy drinking being the historical domain of the middle aged male. That's now changed." (male worker)

However, the liberalisation of licensing laws and women's greater economic opportunities is widely regarded as having costs in terms of women's greater propensity to alcohol-related-problems. Some workers (3) noted the contemporary reduction of the stigma attached to women drinking:

".. these days .. it seems rather that women's patterns of drinking conform much more closely to the patterns that're seen in the male population... I think it's to do with there being less stigma attached to the female drinker - to do with more women working and copying patterns of drinking amongst male drinkers - you know, going to the pub after work - it's to do with drinking being more acceptable as an operation amongst women than it used to be - it's to do with there being far more outlets and women going along to these places not necessarily in

mixed company - it's being more accepted."
(female worker).

"I think women've become more emancipated, they've become more like men in many ways, so they mimic men's behaviour and that includes drinking - not only their work but their play. I think women are imitating men now - they don't spend so much time at home and they've got more opportunities with jobs and money and things like that, so they'll drink as much as men, their lifestyles'll become similar, their roles will become similar rather than they were maybe 2 or 3 decades ago when their roles were very different than they are now. Spit and sawdust pubs're out the window, pubs aren't like that now - wine bars, supermarket sales. It's easier for women to get drink now than it was 20 years ago ...

But there's still the stigma, it's still there, but I think it'll be eroded. It's more acceptable for a woman to go into a wine bar themselves. I remember [twenty years ago] you just wouldn't see them in pubs. So I think the emancipation thing's got a lot to do with it - some occupations, journalists... ransom of emancipation..." (male worker).

Women's emancipation, however, was not regarded as simply the result of women's political struggle; rather it was seen within the context of the capitalist development of industry in general and the alcohol industry in particular (2):

".. women're now targeted as a group for growth within the [alcohol] industry - and you could add young people to that." (male worker).

Changes in licensing laws were seen as reflecting both the development of equal opportunities and of the alcohol industry (4):

"Well you know yourself that the women, the females are going up in the league, they're going away up... and again the point is I hear with people, there's more females coming in [for alcohol counselling]. And I reckon it's through the licensing laws. You see, I'm against this, I don't know what you think about it, but I .. think that the licensing laws are too lenient in as much as that a corner shop is getting a licence whereas in the old days you had to go to a particular place to buy alcohol. They package it to attract females. Let's be honest - well you know yourself you go into a supermarket and it's done to appeal to the wife, the woman - I mean, not so much for a man, for women. And I have clients who coming in here - women, and when they go for the messages they're buying 4 cans of Carlsberg [they say] 'it's good, you know, I feel relaxed when I take it'." (male worker)

And the incidence of alcohol-related-problems was seen as increasing alongside the emancipation of both alcohol and women from economic constraints (7):

"I don't have any doubt in my mind at all that where there's a greater availability [of alcohol] there're will be a greater problem - and there is now more availability where women are - in terms of superstores and things like that - where they can just pick it off the shelf along with the sugar and the vinegar and all that stuff." (male worker)

".. women're now targeted as a group for growth within the [alcohol] industry - and you could add young people to that. And I don't think it's a coincidence that the ratio of male to females [problem drinkers] in now something like 2 to 1 whereas a number of years ago it was 9 or 10 to 1 - the more people that use alcohol the more the chances increase of those people developing problems. Women're physiologically different and can't physiologically drink as much as men, so

damage, if they're trying to do that, can come earlier...

In general terms if you use a drug - a psychoactive substance.. going from no-use to use you immediately increase the chances of dependence.

More women're drinking, so statistically more women are therefore more likely to develop problems." (male worker)

Women's 'liberation', therefore was regarded as exposing women to a far greater risk of damage through drinking:

"[Woman are] more vulnerable to alcohol problems and that's something which I suppose you would understand isn't it - about physical vulnerability - maybe an element of psychological vulnerability as well" (female worker).

Women's vulnerability to organic harm through drinking, therefore was regarded as symptomatic of women's greater social stress. While some workers took the organic/ functionalist view that this was evidence of the pathological nature of the institution of gender equality (10), other workers felt that women were not liberated but further oppressed by contemporary society (6). From this latter perspective, alcohol problems were regarded as symptomatic of women's greater social stress rather than alcohol problems per se.

"Some of the evidence suggests that women .. see misuses of alcohol as perhaps being temporary or symptomatic of other problems - anxiety, depression, or whatever.." (female worker).

"Well from my own experience .. a lot of [drunken women] complain of anxiety - and this stems from.. maybe their relationships with their husband is poor - their children maybe causing problems at school and therefore they've got the responsibility of that. Their husbands maybe just opted out of it - and therefore they just start drinking, themselves, during the day. I find that anxiety appears in a large percentage of drinking problems.

From my own experience I would say that females tend to drink more when their marriage gets into problems.. [or] if they've got an elderly relative of their own to look after, plus their family - sometimes there's a build up of pressure for them and this is ways of opting out." (female worker).

"I think with the stress and strain of modern life and, you know, job situations - this can cause terrible problems, you know .. lets go for a drink. And from there it snowballs.' (female worker).

"I would say in most of our women it's preceding problems .. being sexually abused as children ... a broken home which has very often been because of violent parents - domestic violence which they've suffered as children and as an adult. Sexual abuse and rape. Mental health problems. Low self-esteem. And no access to being able to develop their own skills either in the community or in employment." (female worker)

The social enforcement of women's abstinence, and their consequent confinement in the home was seen by some workers (7) as particularly damaging:

".. a number of the female clients who're referred to us are house drinkers. They're in the house during the day - for want of a better term 'housewives'. They get very bored and very often we find there's a lot of surreptitious drinking that goes on with women that doesn't go on so much with men. It may be something to do with the sort of

cultural image of drinking in Scotland - of the macho male drinker, if you like." (male worker)

"I mean with women .. whether it's a means to actually drown out some problems - and it may not just be emotional problems, but problems I think of feeling undervalued - and I don't know if I'm right here, but women with drink problems tend to see themselves as being isolated and would drink at home rather than drink out in the social environment." (male worker).

"Well my view is that .. a lot of women spend most of their lives in social isolation, with pressures of childcare, pressures of unemployment, pressures of family problems..." (female worker)

Women's impoverished isolation in the home was seen as reinforced by the geographical environment (2):

"It's the isolation up here - it's not a good housing area - its probably the worst part of Drumchapel. There's a lot of single-parents in easy to get houses. So you find there's a lot of isolation... and the post office, this is a petty point, but it's really quite important, the queue in the post office on a Monday - you can wait in the queue for about 2 hours. Now if you're down there on a wet morning, with a couple of kids in the pouring rain, then after you get that money you're going to get yourself a few things, then you've got to get yourself back... There's nothing available to help them...

Now there's the volunteer project downstairs - volunteers organise a creche - they're going to get money. But having said that, there's a group working now - set up a mobile bus first of all, a mobile creche that might help them in some areas. They're trying to develop this a little bit more, but the application...

Men seem to expect, it's expected that men are poor souls really, they need all this help, comfortable refuges. And I don't think

that it's the same with women. Drinking especially, is OK if you're depressed. Depressed and neurotic people don't need that much help, they're told to pull themselves together. There's a couple of doctors in Drumchapel... That's what I was meaning - treatment in the doctors surgery, that's the classic. If you get a guy and he goes down, might have a couple of aches and pains and feeling a bit fed up - and I've actually seen it happen, because I go with women sometimes to the doctors - if it's a man that goes into the doctors - but if it's a woman and she's a bit depressed, well, what does that mean? And that's it, a kind of eye contact and you're feel a bit depressed, and he's reaching for the prescription pad. Having said that there's a new woman doctor who's just started down there, who's very sympathetic... Here [drinking] happens because of the housing - they can't get out. And it's quite a nice thing to do - it's an easy way to give yourself a break, and a couple of friends can come up to the house and bring their children. And apart from the fact that the supermarkets - wine's cheap, Martini's cheap' (female worker).

Women's structural position was thus regarded by half (10) of the workers that I spoke to workers as a major factor in their development of drinking problems. Significantly, whilst 8 of the 10 workers who held a functionalist/organic view of the nature of women's drunkenness were men, 8 of the 10 workers holding a more radical structuralist perspective were women.

Many workers highlighted the general impoverishment and isolation of women, particular working class women (2), and also their general

exclusion from traditional means of stress relief, such as drinking (7):

"The other very significant thing, as far as I'm concerned [is that] women don't have the opportunity to go out socially, for example, going to a pub on their own, therefore their use of alcohol - which as a society we all use to relieve stress, strain, all the rest of it - is very often precluded for women. They don't have that - to be able to use alcohol, on their own, but within a social setting. It's one of the other really significant differences between male and female use of alcohol - its more often they bring it home with them." (female worker).

The 'liberation' of women allowed them to drink alongside men as a means of individual stress-relief; however, the workers noted that women are still prohibited from drunkenness. Insofar as women, despite their participation in waged work, are still responsible for childcare and provide the means of masculine 'time-out', women have no legitimate 'time-out' from their social responsibilities.

"I think in Scottish society its not accepted for a woman to get drunk whereas it's sort of expected for men to get drunk - so I think that women have to contend with that." (female worker).

"I think with men it's historical, in as much as you know it's the macho image.. let's be honest. It's said many times oh aye to go for a pint it's a young chaps ambition - when he goes for a pint with his old man let's say, and it does happen, they go for a drink and it's I'm a man now because I take a drink. That's what it is, that's what I think. I

don't think you have the same with females - the younger type of female anyway, she drinks because it's the done thing in the company she's in you know. Her peer group are drinking, she goes into a pub and Jessie so and so, she's having a half pint of lager, and she'll have a half pint of lager with her. And it's rather more to keep up with - to be the same as the rest. I don't think there's anything in it - but the young man has got the other - you know he's a man now that he's got his pint, and it's a man too to be drunk - that's really being a man... But I know myself that's what it is, I mean just take a boy with his apprenticeship - when his time's out as an apprentice what does he do with his first week's wages - which is an old fashioned thing - but they go and they take all their mates out - the blokes that they work with - for a drink and some of them get smashed - and the young fella's got drunk as well." (male worker)

Women drink, but cannot get drunk: several workers

(8) noted that the incidence of sexual violence seemed to increase alongside women's greater participation in public activities, such as drunkenness.

".. the number of women who have drink problems is rising. All the time. And the reasons for that are manifold. In some cases higher disposable income. Pressures of work which weren't there before. Expectations of others that women should make a career for themselves, which maybe in the past wasn't expected of them - might not have been what they were brought up to believe. There seem to be more instances of brutality - husbands towards wives, for instance. I'm sure that could lead to women drinking." (male worker).

"It can be more dangerous, just physically more dangerous - which means that sometimes women will attach themselves to men just for the safety - sexual abuse - it's like some women wouldn't see [sexual abuse] as a

problem because they just see it as part of life - they wouldn't make a big thing about having been raped... " (female worker).

Being drunk, therefore, was seen as incurring sexual violence: men's violent consumption of women, and thus the explicit reinstatement of women's status.

"The only women I've seen drinking with men, apart from obviously social situations, are the women that service the men in alcohol schools, you know that exist both in Scotland and England, you know, basically a service provided to get alcohol." (male worker).

In addition to the informal and violent penalties that drunken women are likely to incur, some (4) of the workers that I spoke to observed the formal, state-enforced enforcement of women abstinence and confinement in the home. They thought that any inabstinence was likely to lead to the woman being defined as an alcoholic by social welfare agencies:

"The main problem of being a woman in relation to alcohol is that you will have - you'll be early identified as having an alcohol problem - you'll be defined as being more deviant if you have an alcohol problem - your domestic duties will be defined as lacking by that and feel threatened by that. You will not have the support system available that men have - a spouse, family et cetera et cetera. If you do have it.. in a great many cases it's very negative support." (female worker)

".. the female clients are more readily defined as having an alcohol problem." (female worker).

Women's prohibition from drunkenness not only led to their labelling, but also to direct state intervention in their lives.

"In terms of their alcohol/drug use then obviously there's a huge double standard exists basically whereby it seems relatively OK for men to drink and become drunk, whereas for women it's a lot - for women on the other hand there's a huge stigma ... Women usually, not always, but usually are seen as the primary carers of children and therefore - looking at our references from the social work department, then those that have been made priority [are] because social work are saying that about the children... It's very much seen as that in the family if the husband's drinking then that's not .. necessarily childcare, a childcare problem." (female worker).

"The average age of the client here is 40, which is true for Councils on Alcohol as well - great play is made of do you have creche facilities. Now at 40 most people's children are teenage or in fact married, so, the majority of patients that we have do not in fact have small children. There is a subgroup that is different. And they're an unusual group in that they're referred to us by social workers, and they tend to be a bit younger and often the reason for referral is that they're having difficulty caring for their children. Their children're maybe in care or about to be taken into care. So obviously the child aspect is important. But we're not directly involved in that - social workers tend to have made arrangements for what happens to the kids. So we don't tend to do that, we don't get involved in that, purely because the average client's that bit older." (female worker)

"If they are pregnant there are likely to be problems. They are also likely to be .. submitted to pressure - in terms of if they are in hospital during pregnancy and they see a social worker, it now seems to me to be

becoming quite common for a mother who isn't prepared to give up that the child will automatically be put on an 'at risk' register." (male worker)

".. their house and their kids been taken from them." (male worker)

The observations of half the workers that I spoke to, therefore, indicated that the functional definition of women as essentially abstinent was socially instituted through their effective social isolation in the home; and reinforced through the threat of sexual violence and of the state removal of their children in cases of drunken inabstinence.

In group discussions and individual interviews with women in treatment for drunken inabstinence, the enforcement of women's abstinence was identified as a major factor in the definition of women as alcoholic/problem drinkers. Some women described how their husbands prevented them from engaging in waged work (8) and forcibly stopped their contact with family and friends (4):

"Five or six years ago I was cut off from my family because of my man, he wouldn't let me out and I wasn't taken out socially. Now I drink because of loneliness, because of anger, for lots of reasons. I feel trapped now - I fear him mentally, not physically... I wasn't taken out socially so I would have fantasies when the radio was on. I sometimes drank in someone else's house and would get

drunk. I was angry, frustrated that I couldn't get out, that I was wearing the wrong lipstick, so I began to resent my husband. I drank and it felt OK, until I remembered that John [husband] was coming home, and then I got angry and shouted... It's as if he wants me, but not the way I am [sober] - not letting him dominate me. I can see things clearer now, he doesn't like it, he takes money from me so that I can only have shopping money. I have to give my sickness benefit to him. There's no trust - he's putting me back to where I was 5 years ago.

In sobriety I hate the man I live with. I can't have him near me. He tells me when to go to bed - at 9.20pm - and slams the doors to wake the kids if I don't. He wants me in bed with him all the time. Once I'm away then it's my choice whether or not I drink. Trust from him is not important - I can trust myself now. I can see now and I don't like what I can see - I do everything to perfection for him. It used to be a choice between the bottle and sex from him, now I just have to say no. Now John's a bit jealous - I've got my looks back and he's not beautiful. I feel that he's waiting for me to go back on the drink." (Cath)

"I felt like a child, he talks to me as if I'm a child..." (Christine)

"My man didn't allow me to have any friends.." (Diane)

".. men don't like women to have friends or independence.." (Liz)

Marriage and the demands of the social role of wife and mother, therefore, were frequently mentioned as a reason for drinking (12):

"I started drinking when I got married. We got separated 9 months ago but we're been back together now. I drank socially to start off with, when I was young, but then I got bored and lonely when my man was out. I was

bored and drank to get back at my husband - he doesn't like drunkenness." (Gill)

"... drink helps me cope with marriage."
(Mary)

"But you can't always keep yourself busy - when I get lonely I [try to] keep myself occupied." (Frances)

"The days were the bad times so I drank."
(Agnes)

"I can't get through the day without drink."
(Fiona)

"[I started drinking] 10 weeks after my daughter was born." (Helen)

Loneliness due to the expectation of (married) women's abstinence from waged employment and social interaction was cited by most women (28) as both a cause (17) and a consequence (11) of drinking:

"I always feel lonely, can't get out of the house - I need to fill in the day - now I do voluntary work, swimming.. its a struggle.." (Joanne)

"women are insecure, lacking in confidence, can't communicate, lonely, and one thing leads to another: there's company in that glass - company and drink." (Susan)

"I have no friends." (Agnes)

"I'm scared of loosing my friends." (Nicky)

"I'm fearful in the house myself, when I have a drink I feel sorry for myself, when I'm sober I feel guilty." (Louise)

"Then my mother got ill and died in 1984. I'd always lived with her. She died at 6.30 in the morning and I went out of my mind. I was

so lonely and started to drink - anything."
(Frances)

"[Before I came here] I drank morning and night, alone at night watching telly and during the day. Always on my own [never socially]. I just couldn't stop - all on my own. I had no friends. The only friend I had was the bottle. [It lasted] 19 years [and got steadily worse]. (Helen)

"I can't speak to neighbours and people .. agoraphobia .. everyone's staring, talking about me." (Rose)

"I never went to parties, I preferred sitting in... in my own house I can enjoy drinking. People thought I was a bad person because I drank alone." (Annie)

The strictures of women's role, therefore, were generally felt to be such that drinking provided some relief. The women (11) recognized also, however that it was a false relief, as drinking and drunkenness actually re-enforced their domestic isolation:

"You loose [your friends] if you're an alkie - you're often rejected and hurt." (Kate)

"I don't have any friends so its safe [to drink] alone." (Fiona)

"If women drink behind closed doors its [seen as] disgusting." (Jenny)

The double standard of drinking and drunkenness was seen as a major factor in the further domestic isolation of inabstinent women (3).

"I think that women getting drunk at parties are moderately worse than men getting drunk at parties. Men's attitudes to women drinking

are sarcastic, they don't approve. I drank alone and got a drink problem." (Gill)

"People think its more alright for a man to be drunk than a woman. They just walk by a woman." (Annie)

"They think that women drinking is not OK. I don't like pub drinking, but I did it, I felt terrible, as if I was being stared at."
(Annie)

The double standard, based on women's functional role as a wife and mother, meant that the women felt that they should hide their drinking (3).

"I started to drink socially and then I began to drink for a reason, I'm 53. My parents were a pressure in the house, so drinking was a secret during the day. As the pressure got worse I drank more. I took it to calm down then my health got bad and I needed help."
(Agnes)

Furthermore, some women (5) also felt that the availability of alcohol in shops and supermarkets reduced the double standard of drinking and the stigma attached to inabstinent women slightly.

"It looks better if you get alcohol with your shopping - pretend it's Charlies dinner..
(Mary)

"The shop is handy for whiskey and lemonade."
(Gill)

The assumption of the liberation of women simultaneous with the liberalisation of licensing laws, however, was generally refuted by all of the women that I spoke to.

"If I had my chance again I'd make sure everything was equal. You've got a million

and one jobs - they all have to be done."
(Susan)

"... divorce, marital problems (constant nagging) children, pressure on life if your man isn't pulling his weight, responsibility - if you can't beat them join them - all men drink." (Kate)

The increasing pressure on women to fulfil domestic and unwaged/public roles meant that some of the women (4) I spoke to felt that they couldn't cope well - drinking enabled them to function. The women generally felt that their drinking did not adversely affect their domestic or waged work, rather it helped them to stop feeling the pressure.

"I never had a drink at work - I was occupied. Drink involved kids .. I avoided drinking with the kids if possible - kids don't like heavy drinking - it's OK if it's not heavy, OK if it's Martini, not vodka."
(Jenny)

"I always managed to get to work." (Gill)

Many of the women (11) said that they drank to escape the feeling that they couldn't cope in the face of practical difficulties, physical or emotional pain. Furthermore, they tended to think that alcohol was more effective than prescribed drugs (10).

"Prescribed drugs aren't strong enough..
(Kate)

"Alcohol is stronger than prescribed drugs, I've been on everything.." (Susan)

"Alcohol effects your mind more than tablets.." (Mary)

Divorce, marriage, children and homelessness were mentioned as specific practical problems that women face.

".. in marriage everything should be shared, discussed - communication is important.." (Jenny)

".. the divorce made it worse, I had nothing, alcohol blots it out - all the practical problems, the children into care." (Nicky)

"I was guilty that I couldn't cope with my son's handicap. Now I'm learning how to cope.." (Joanne)

"[Homelessness] is easier to deal with when you're drunk." (Christine)

In terms of physical pain, the women I spoke to mentioned general illness (2), but also pain through male violence (10).

".. [drinking] helps ease pain.." (Mary)

"I started to drink when I was 14, it was OK, I just did it. I drank with friends. Now I drink by myself - or with my husband, who has a drink problem. I used to drink for pleasure, but now I drink when I'm depressed - I feel better after I've had a drink. I started drinking heavily after my husband battered me and knocked one of my eyes out and I got up to about 6 or 8 cans daily." (Annie)

"I started drinking when I was 21 and I had a whiskey at Hogmanay. In 1972 I began to drink heavily for 4 months - I had 3 operations - my appendix, my mouth and 3 pins in my ankle, from the mill work." (Frances)

Many women said that alcohol helped them to stop their feelings of rejection, helplessness or desperation (9).

"I wouldn't know, that's the reason I drink, because then I feel OK. You could get involved and not realise it - see that's the reason I keep drinking.." (Fiona)

".. [alcohol] makes you forget everything.." (Louise)

".. they say [alcohol] cures all your worries - but the next day... its just the same - you're drinking one day to drown your sorrows and you're waking up the next morning to just the same thing - even worse. I've done that the other day - go out and get a couple of Carlies and took them down to the house with me and sat them on my own... you just say to hell with that, you see this is it.." (Rose)

"I done it to forget it - just to forget.." (Louise)

"My boyfriend left me when I was 18 to get married. I had one child who was adopted and that was when I began to hit the booze. I felt rejected - my boyfriend slept with me the night before he got married. I drank to relax, but it made me morbid, I got things out of proportion - my baby was a problem so it was then adopted. Now when I drink I talk about the past - my boyfriend. I drank superlagers because they were cheaper." (Debbie)

"Men .. are the problem - they make you feel inferior. I don't feel good enough - ever" (Mary)

Helen's story perhaps best illustrates the loneliness and pain of women's 'traditional' role as wife and mother, in particular the profound dependency that she has on her husband.

"My mother and father - well my mother really, she was very strict about religion and I won't mention the religion. And anyway I met this chap and wanted to get married - my mother told me that I was not his kind, that I couldn't be in her house [if I went with him]. So we went to England and we got a bedsitter just before Christmas and we got married in 1962 in a registry office. So I lived down in England ... I worked for 6 years. And my husband was with a furniture firm ... I fell pregnant in 1969, 6 years after we were first married ... and I had .. my daughter Tracy. So I went into hospital for Tracy on the Friday night ... and got discharged on the Monday morning.

Well my husband didn't drink, but he .. played cards. And all I knew was that he went to the pub and it was a really heavy game of cards - gambling - and I didn't mind. But after I got out [of hospital after having Tracy] on Monday morning .. my husband came in and he says 'that's me .. I've got no job, I had a row with the accountant and the manager's accused me of stealing money from the firm.' He says 'I'm not going back'. So here's me, a new baby who's premature .. and my husband with no job. So I says 'oh well, that's it then'. So I goes to my sister [and told her and said] 'I don't know what to do'. I had one brother who'd moved down beside me. [and I went up to Glasgow, my husband, Billy was to follow]...

So the next thing [was that] Billy [couldn't] come up: he's to wait 6 weeks for his case to come up - and it was in the local paper: 'local man .. wife with premature baby and husband stole from firm'. ... and I went into that witness box and I said in front of a judge and jury - the jury was mostly women - I said I went into hospital for a premature baby and I needed a cot - the prosecuting barrister was very kind. So I came out of court. [Billy didn't get off and I started working again] but I wouldn't go out - I used to get up at 5 o' clock in the morning and hang the washing out - I wouldn't go down to the shops, because I thought all the

neighbours were watching me, talking about me. I hated going into crowded places - and it was even a big step for me to get on the bus... I was the wrong class, you know, Scottish.

Friends dropped me during the court case - except one, Jill, she was self-conscious because she was on the fat side. After the court case Jill used to come and visit me and she'd drink lots of coffee, so I'd make her a coffee and she'd be sitting there and I'd go into the kitchen and I'd pour a cup of sherry - a full teacup full - so she'd be there sipping her coffee and I'd be sipping my sherry and she'd say do you like black coffee and I'd say aye...

So one night I went down to the shop and see all the drink and I thought right I'm going to have some vodka, they say it doesn't have a taste. So I gets home in the dark and I had a drink and I didn't care about the neighbours. I don't care about anybody. And I drank, and anywhere I went I took a drink with me and then I got that I couldn't do without the drink. And this went on and on until my daughter was about 7 and then .. [I went to] hospital, got dried out and .. [my husband] told everyone. And then he didn't like me - he liked me sort of stupid [drunk] I got out at Christmas and he said have one, one [drink] won't do you any harm. So I had one...

So this went on and on and then - I stayed with my brother for a wee while and I thought [my husband] won't be able to cope with getting my daughter out to school, taking her back from school - so I went back up to my own door and he'd changed all the locks on the door, so I started banging on the door and he came. And I said [that] I wanted my own daughter - and I'd do it the right way. I'd do it through the court. So I went to Coventry to this meeting [with social workers and stayed in a Salvation Army hostel] and this mister .. took all your giro and gave you £4 - to buy tights and make-up and deodorant - so anyway, I just stuck there - lesbians, prostitutes, everything - and this

one she said 'I've got a drink problem but you don't know what I am' - and she opened up this case - leather trousers, jacket - she was drinking heavy. She said she was using the men's toilet one night and somebody raped her, when she was in the men's toilet in a black-out - what an experience.

Well anyway, so I was the only one that was working [in the hostel] and I used to leave in the morning and I was to early for breakfast so in the morning I used to walk down and get chocolate out of R.S.McCalls, and then at night I'd have to buy chocolate, because I'd missed tea.

Well I kept going for 2 years, but in-between the 2 years I'd went to the council and I'd told them the position - and finally I got a flat with the council. But here I was with a lovely flat - which the rent was £18 - but I had no furniture. So I was told to go to the welfare people and they'd give me furniture. So I did and then she told me that, me being working I had to pay it all back, so I never got a cooker. All I got was one chair and a bed. I [couldn't] afford to pay my rent and buy furniture too - I was drinking, but not during the day, only at night.

And then one day I had a phone call. In this time my husband divorced me. He divorced me - and then I had to go to court and I couldn't go to court sober .. to get custody of Tracy and access to Tracy. So I went to court and I lost it. So, this was before I got the flat. And then I had to go for access and I was refused access - so - I got a phone call from the social security asking me if I would meet my daughter. I said yes, of course I [would] - and I took a day off work - and the two of us were chatting away as if we were good friends. The out of the blue [my husband] said 'I'll tell you why I came .. I'm not allowed to take Tracy back to Scotland .. I've got a change of job in Scotland and Tracy and I've been up there on holiday and I've got a house .. a council house and if you give your consent for Tracy to go, what I'll do is go up first, start the job, do the house up and then you could come up later and live with your mam and then you could come

and visit us every weekend.' Marvellous, so I thought .. so I went home that night and sat up all night working on this letter - of course I'd had a drink, I couldn't .. I just bought a bottle. Anyway the next thing I'd heard was that he'd gone back to Scotland with my daughter - my mum phoned me and she says 'your ex-husband's back here and your little girl, but we're not allowed to see them .. I'm the only Gran she's got and she walks past me in the street'. So I just .. packed my stuff and jumped on a bus from Coventry to Glasgow.. I didn't give in my notice or get any money that was due to me. My mother told me where he lived and it was just round the corner from my mother. I went to his door and every time I went to the door...

I had bottles hidden in every corner in my mother's ... my favourite place [for hiding the bottles] was in my boots at the bottom of the wardrobe - my coats would hide it and the boots were deep. Even when I was going out to the AA I was drinking - you'd have one ear on the bottle - click, click - and the other ear at the door. I didn't want to eat to spoil the effects of the alcohol. I'll have to train myself to sit and relax and watch the television without a glass in my hand - I used to do a lot of knitting, so I'm going to buy a ball of wool.

And then [my mother] put me out and I went to live with my sister and finally she put me out and then I went and lived with my mother again. And I was living with my mother [when] my mother's sister died .. and she asked me to go to the funeral. She says 'I need company .. I'm too old to travel from Airdrie to Gourock' So I went .. and of course I hadn't had anything to drink on the train and by the time we got off I'd started to shake - and Jimmy noticed me shaking and he says 'I think I'll take Helen down for a refreshment' So I thought right Helen, I'm not going to drink with a strange man, because my drinking was always on my own all the time. So we went to the pub and he says 'how long have you been drinking' and I told him all about it. And he told me he'd been worse. So anyway, he

asked me if he could come and visit me - so the next Saturday he came over and the friendship grew from there. So the next thing I knew .. he got me a beautiful ring - an engagement ring - he bought it, he paid for it, but he stole an old ring out of my mothers, that's how he knew what size to get. So anyway we got married. He kept asking me to marry him and I said 'well I don't really know'. I thought well, he's good company and he's a good friend and I really need him: when I was down and drinking .. he was really good to me. And I really needed him. The feelings of rejection - my husband had got rid of my feelings, so Jimmy's attention was good for me. I needed it.

So anyway, he'd had an alcohol problem, so he got me into the hospital at Airdrie, so here I was getting dried out again. I was in Hartwood Hill [hospital] for ten days drying out and from Hartwood Hill I got transferred to Airdrie [hospital]. By the way, I forgot something, I took an overdose at my mothers - I'd no drink this one night and my mother'd gone to bed and I was watching television and I knew my mother had this bottle of vodka which'd been lying in this cabinet for years and .. so I looked at the bottle of vodka and I thought I'll have a little drink and fill it up with water and she'll not know. So once I'd opened the bottle I had one and another and another and another, so anyway I had these tablets, 100 tablets, so with my last glass of vodka I took the tablets in my hand and I swallowed they 100 tablets, swallow, swallow, swallow. My mother came down the next morning and I was jammed between the table and the chair unconscious. She called the ambulance and they took me into Monklands [hospital]. I was in there for a week, stomach pumped. So anyway I had to transfer from Hartwood Hill [hospital] back again once I'd dried out. I went back to this course and .. it was all men and I was the only woman there. But slowly but surely most of them dropped out. Then there was only about 5 or 6. So anyway after 8 weeks - by this time I was sober. At the end of the 8 weeks we were all waiting to get discharged and the doctor came to me and said 'Helen we want to re-

admit you'.. So I had to get to Monklands [hospital], not every day but on a Tuesday and a Thursday and then it got to be just a Thursday.

But in this period of time Dr X used to come to my mothers, pick me up on a Saturday morning when he was off duty and take me to the shops and stand outside the shops while I went in and I'd come out in a panic - couldn't breathe, walk, shook. So then he decided that, and he said 'right take a piece of paper and a pen and go up to - and buy something from the shop and come back'. These're the things that he made me do, which was good.

So - I was [hiding since the] court case, couldn't get out of the habit and I took the drink because it was like a shield over me you see - no one could see me. Anyway I came out [of hiding and hospital] and stayed off the drink and I got married to Jimmy and .. he got this house where we live at the moment. So we moved here - and it was one Christmas after 18 months of sobriety I said to my husband 'I think I'll have a Babycham to bring the bells in' and he said 'do you think you can handle it', and I said 'yes, surely .. a Babycham's nothing to me - 2 bottles of vodka maybe .. a Babycham's just a beverage' and he said 'alright I'll get you a Babycham'. Well it only took that Babycham... It gave me [alcoholic seizures] Sheila, but I'm safe now [from alcoholic seizures].

I find I think about alcohol - don't get me wrong, its really hard - weekends I got really down .. because my husband works at weekends, all day and my drinking habit was plenty [alcohol] on a Sunday. He loves me very much. I know it's terrible to say, but I don't really love him. I like him and I love him as a friend - but to be madly in love with him. He gives me the payslip - he's one in a million - and he likes a little drink, but only at weekends. I've known him 4 years and what he's put up with in they 4 years, I wouldn't've stuck him.

And I'm 52 - I feel like I've lost 20 years of my life.

I send [my daughter] a Christmas card every year .. and I get it returned .. [saying I] don't want anything to do with you. I always put a £10 note in it, and the whole lot's returned - .. cards, £10 note .. [and] written on the bottom [is I] don't want anything to do with you. And my husband said 'why don't you write to your daughter - sit down and write a long letter'. He's been on at me for about 2 years to do this, he says 'because I can't think it's right .. [your ex-husband] must be really bad to keep his own daughter away from her mother'. So I sat down about 2 weeks ago [and] about 4 to 5 days later I got this letter from the lawyer and it said that I had ruined her life until she was 9 years of age, and now [that] she was nearly 19 to stop pestering her. Do you know I was actually sick. So that was that, so I've just said I'll wait until she's ready...

... my young niece, [who] goes to discos, [saw] my daughter and she said that [my daughter] asked if she looked like Auntie Helen - she said 'actually you do look like your mother Tracy', and she said oh - so she's started to ask about me...

It's as if somebody's put a blindfold over me for the past 20 years." (Helen)

Helen's story describes her loss of social status, and even existence, through her husband's inabstinence: the darkness of night and of drunkenness enabled her to escape society and the judgements that she feared. As her dependence on (patriarchal) society dissolved into dependence upon drunkenness, she lost her child and nearly her life. And through her re-marriage, her

dependency upon her new husband replaced her
dependency upon alcohol: her inabstinent
dependency upon drunkenness and social
invisibility was transmogrified into an abstinent
dependency upon marriage and domestic
invisibility.

Where Helen described her emotional impoverished,
Betty described her economic impoverishment:

"[My husband] was made redundant in 1966 and he got £600 - and he got a job in the post office. It was years ago I should've started drinking. When he came in he never saw the weans at night, he was too drunk. When he retired he stopped it - he's not going to [put] that money in the bank though...

See I worked out that's where I made the mistake - I put my money in the house and covered the weans. And I thought that the two wages he was earning, that he was putting it away for later on, you know. I worked through all that, I worked in the school cleaning as well - and its heavy cleaning, lifting big desks and working 3 weeks until [another child] was born and the janitor said 'my Betty what've you been doing?' I had the wean two days after. At the time I thought I was fit, but it's all telling the now - outside ten years on the night shift, cleaning buses - it's hard. I tell you now I've got chronic bronchitis, I take a heart tablet twice a day now....'

So this brother that died in England - he had so much money, but I didn't come into it, I didn't get nothing, but then ...

I can bypass a pub. I can go to bingo and see drink in it and I don't buy it, I buy a cup of tea. I mean I don't go near a pub - it's

just my man. Forty years married - I said to my social worker, but I think I'll be too old to get a divorce. See my man now - I've got nothing, he buys the family, he buys their clothes and ...

My man was made redundant from the post office in 1966, he got £600 and I've seen none, he's mean. He boozed until he retired and knocked me about but I belted him back.

I'd like to have something for myself."
(Betty)

Women's dependency upon men in order to achieve social status/existence is premised upon their abstinence from public participation in the form of waged employment and thus of legitimate leisure/pleasure. This is necessary in order that men are free to participate in public activity, and thus also to express their 'essential' masculinity. Such patriarchal expression is secured through the maintenance of the functional relation of production with consumption through women: women are confined in the sphere of consumption through their abstinence from social intercourse. This means that women (especially working class women) have little or no access to money or material goods. And further, as modern human expression is now conceived in terms of inabstinent consumption - of 'time-off' from waged work, leisure - which is legitimately enjoyed only through waged work, women (especially working

class women) have little or no access to leisure/pleasure. Women are denied both production and consumption, both socially valued and recognized work and the possibility of leisure/pleasure.

Furthermore, insofar as women are the locus of consumption, they are also the means of men's leisure/ pleasure. Contemporary women's greater participation in the waged workforce has not qualified them for leisure/pleasure, rather it has further reduced women's opportunities for 'time-off'. Women are expected (and expect themselves) to be wives and mothers as well as waged workers; and women who inabstinently pursue their own leisure/pleasure are subject to sanctions ranging from health and welfare intervention to sexual violence. All of these sanctions are effective in reinstating women's abstinence and their functional dependency on men: all of these sanctions, therefore, are effective in maintaining patriarchal structures of expression.

Helen's story described her movement from alcoholic to patriarchal dependency. Betty's story

told of the consumption of her money by her husband and her family - and thus of the feeling that her entire life was consumed by others and lost to herself. In their drunkenness, both women caricaturised the enforcement of women's dependency through their patriarchal consumption. Both Helen and Betty told of their lack of opportunities for self-realisation and pleasure.

Several of the women (17) that I spoke to told of their search for pleasure, or 'time-off' from their social subscribed responsibilities. Drinking was clearly seen by some of the women as a means of relaxation or pleasure; for some the pleasure was solitary (12), for others it was social - with other women (7).

"When I watch the likes of Dallas on the TV in the afternoon I drink and think I'm on Dallas - Sue Ellen with a superlager! Now I have juice while its on instead." (Christine)

"There's no alternatives to alcohol - except maybe sport - sport helps you relax and gives you a routine." (Mary)

"You deserve a drink at the end of the week.." (Diane)

"You're happy, it's just like being in fairyland'" (Frances)

"Drink gives you feelings, makes you feel good; but you feel no better the next morning.." (Fiona)

"I drink if I have problems, to forget, but my purse is lighter.." (Louise)

"I drink to relax but not to get drunk: you get a sleep, some enjoyment.." (Susan)

Most (23) women saw drinking as synonymous with housework:

"I've a job in the house so I drink in the house.." (Agnes)

"I have my social life while my man is at work.." (Liz)

Some women (7), however, enjoyed drinking in pubs to meet other inabstinent women:

"[drinking] helps to find women in a similar position.." (Kate)

"I used to go out of the house .. this time a month ago I'd be sitting in the pub by now, and that would be everyday, Monday to Friday, for me [drinking is] pleasure.." (Rose)

"I like going to the pub, because you can get a laugh and that .. I used to sit and tell dirty jokes and everything, get a laugh." (Louise)

"I used to drink for pleasure in the pub, to get a laugh, it was a social thing, every day 3 months ago. My other friends were hoity toity." (Fiona)

These women were ambivalent about the 'time-off' that pub drinking provided as the dialogue below indicates:

Rose "Pubs are OK if you're lonely, people are friendly, there's music, entertainment.."

Louise "I tend to go into one [local] pub .. in a strange pub I'm fearful that something

would happen - a bad crowd of men would take advantage of my body, my money.."

Rose "A lot of people go to pubs because they're lonely.."

Louise "If it's alright for a man it should be OK for a woman."

Rose "I've seen myself going into a pub .. if I'm lonely.. and I have a few drinks .. Sometimes you get depressed .. because while you're on your own you can think. Sometimes when I go to a pub I sit on my own and then I probably meet other people .. [who] want you to sit with them .. they don't know what's on your mind .. so you can meet them and enjoy their company...

I go into any pubs at all... I'll just stot from one pub to another and because they've got bands you know .. its good entertainment you know, pub crawling.."

Fiona "I never went out pub crawling, I was used to sitting in the house.."

Louise "[I wouldn't go into a strange pub] no, I'd be too feart in case I got drunk - you don't know what's going to happen to you - I think they're liable to take advantage of you.."

Rose "...that's like me, you know, and getting drunk. Because once you're drunk you don't know what you're doing - you think its a great time because of the company .. you are all in together so you say 'oh this is good, this is great', and you keep drinking... They take advantage of your body."

Louise "That's what I think.."

Fiona "If a man wants sex you're too drunk to stop him.."

Rose "... and people like that, they say 'where're you going?' And I'll say 'home'. They say get into the car with us.."

Fiona "Oh I wouldn't get in a car.."

Rose "You think it's a good thing because you're walking in the rain and your minds absolutely blocked... You don't know what you're doing, you think its a great thing."

Louise "You can't control.."

Rose "... you can't control your mind, you don't know a right thing from a wrong thing.."

Fiona "Do you not think that you shouldn't go home with anybody else.."

Rose "As long as.. if you go home with somebody else - you don't have any money - you go home with somebody else [and] that's a carry out, see, you'll do anything to get a drink."

Fiona "Do you not think that if you haven't got money you shouldn't go into a pub?"

Rose "No I don't do that. I'm talking about when I've got money see, if I go into a pub and I've only got £4 .. and I wanted more and I say 'I'm skint, that's all the money I've got'. I always go into a crowd .. so as they can buy the drink, buy the carry out. I mean they'll not say to you 'away you go, what's this, who's she?' If you've got a bad crowd then its no use .. with a bad crowd they'll take advantage of you .. its your body - a bad crowd of men actually. Ladies .. that's an alright crowd, but if you go into a bad place the thing is - you know.."

Fiona "They think you're easy.."

Rose "They're probably saying to themself 'oh this is a good thing'.."

Louise "I don't like to see a woman drunk, yet I can drink.."

Rose "See if you see a woman coming along and she's drunk, you say to yourself 'oh my, look at the state of her, what's she like?' Well that's us! Only we don't see ourself that way .. disgusting .. terrible. And yet we're the same, we don't actually see ourself.."

Louise "Well put it this way, it's OK for men to do it, so why shouldn't a woman do it? I don't care about drunk men, I'd help a drunk woman if she'd fallen down or something like that.."

Rose "You care about women."

Louise "Yes, as far as I'm concerned, I mean, they take advantage of a drunk woman.."

These women enjoyed going to the pub as a means of relieving loneliness, and felt strongly that if

"its OK for men, then it should be OK for women" to drink and become in pubs. However, all three women in the above conversation noted the double standard operating in their very clear awareness of the risk of sexual violence by becoming drunk in public. Most of the other women (22) I spoke to were painfully aware of the dangers of sexual violence in being publicly drunk:

"[If a woman goes into a pub] on her own she's asking for trouble .. right away she's a whore." (Jean)

"I've never been in a pub myself - I suppose you do get men chatting you up if you're yourself.." (Pat)

"I don't like drinking in pubs myself, it's not nice to see women [by] themself in pubs." (Gill)

".. you're not alone [in a pub] unless you drink with girls - then you're a pick up." (Lesley)

"..pubs are trouble so I avoid pubs.. " (Nicky)

"I don't want to be seen drunk in pubs.." (Agnes)

"[drunkenness is] bad if it's in the street, but worse if you're in a pub.." (Rona)

"Anyone takes advantage [of a drunk woman] - you'll be mugged or raped or different things... anyone is vulnerable." (Alison)

"Now I only take out so much money to the pub so I have enough for fags and messages." (Eileen)

"Women are more vulnerable than men when they drink." (Linda)

"I was broken into five times. I know I have a drink problem. They were picking on me, saying 'she'll not miss anything, she's an alko'. If I had any money I wouldn't be here. In 1972 I got a carry-out and met a man. He attacked me, I was 42. I was a virgin. I went to Gartloch [psychiatric hospital] for more than a year. I still feel dirty. And then I got to drinking - to forget all about it. I just didn't want to live anymore. I tried to kill myself twice when I was drunk and I burnt my arms with cigarettes...

I'm going to get a new door and locks and paint the house and not drink my money."
(Frances)

Alison "I couldn't go into a pub, I couldn't go in.."

Rose "Well I've been in pubs and I've sat myself - I can talk to people now, because on your own, it's bad .. especially when you've nobody. You can get murdered, you can get raped you can get stabbed... See once you're drunk, you think it's marvellous, you feel on top of the world, you're more confident with yourself, you think you're great.."

Eileen "I've seen fights in pubs and I get out, leave them alone, even when I've had a good drink in me, when I see fights starting I just walk out the door - it's dangerous. No, I don't [like to] feel out of control, no way.."

Rose "There could be a fight at my feet and I wouldn't know.."

All of these women recognized that being drunk was a licence for men to sexually attack them. Some women (5) suggested that one reason for this may be in retaliation for "cutting your man off with drink": in drunkenness women begin to feel free from the demands of abstinence, they may neglect

their housework, their children, the demands of fidelity to their husbands.

".. drink cuts your man off." (Jean)

".. you're on your own and you can do anything - go with men, drink.." (Frances)

However, all of the women I spoke to felt that this was a false, or at best a very short lived freedom. Sexual and domestic violence were effective in reinforcing women's status as a means for masculine expression.

"I'm scared of my man, terrified and shaking.." (Linda)

Public drunkenness, therefore, was regarded as putting women at clear risk of explicit (and violent) sexual sanction. Furthermore, public concern about the general health risks to women drinkers seemed to be increasingly effective in curtailing women's inabstinence:

"When you drink you show yourself up, you fall down. I know that because the weans tell me. I apologise when I'm sober, after telling people how awful they are to me - I have to be drunk to so this. I can't remember everything, it makes it worse. There's signs of damage, going around the bend. Weans, people steal from me. I'm fear't that the house will be broken into, feart to stay in and to leave the house." (Eileen)

"In fact I would've killed myself. My doctor said, in fact, had I stayed out two to three years more I would've had a heart attack because my lungs were so swollen with fluid. I would've crushed my heart. And I was

getting weaker and weaker and weaker.. And my doctor said it won't get any worse if I don't drink, but if I drink ... I might as well take a spade and start digging my own grave - frightening. And my doctor said if I don't drop dead with a heart attack through time, I'll have cirrhosis of the liver and that's a slow death..." (Helen)

Still more effective in the enforcement of women's abstinence than public health education, however, was the intervention of the health and welfare services. Several women (13) were only attending treatment agencies in order to maintain the custody of their children.

"Then I slipped and had the kids panel in November 87. The social worker, a man, found out - but he said I don't think there's any detrimental effect, they're bright kids. But that left a threat behind me, a fear. I went to the AA then I slipped and then the kids had to go to a panel so now I'm here. I feel bad about my decision to [have] Michael [adopted] - I will never see him... I worry about my other kids - and Michael.." (Debbie)

"I just wanted to drink and that was it. I was on my own. I just used to sit in the house .. [and] I just wanted to go out and everybody'd be drinking, so you'd drink... I liked it, and the only reason that I stopped it just now - it's been a fortnight now - is they took my wean away. I get my boy on a Tuesday and on a Thursday. I don't like him to see me drunk, in fact I'm not allowed to touch drink at all now. See I was allowed a drink, a social drink, that was the only bit, but a social drink, but it wasn't ... don't tell her [social worker]. I'm an alcoholic, that's why I lie. I get on well with her [the social worker]... See if I had my boy with me, [if] my boy was in the house and I'd never started to come here, I'd be in a pub [just] now. I'd have

all my messages. I've seen us [waiting] on the pub opening in the morning and that wasn't only one day, that was five days a week.

I come down here on a Monday and get [my son] on a Tuesday, down here on a Thursday. They do help [here]... say I went out last night and I got drunk, came down here .. its no use saying you're not drunk, you're not drinking, you know you're sitting in the house yourself and thinking to yourself and thinking to yourself I could be out getting drunk. They're straight in here... They're not like social workers here, they just tell you straight to your face .. we all come in here and .. nobody's leaving if we smell alcohol on them.

I go to a pub after here with them all - we all just follow in a line as if we came out of a class, follow the leader.

I drink for enjoyment .. hated sitting in the house, I wanted to go out like everyone else. I don't let the wean see me drunk, they took him away because of the alcohol.

They're good to the weans here, at Christmas and things. You can bring your weans here. If I still had my son I'd be in the pub by now [it's noon].

I've made friends here .. they explain things to you here, talk to you straight.

Probably when my son leaves home I'll drink again." (Elsa)

"I lost my eye and got an eye patch. I thought that people were staring at me so I started drinking. When I was drunk I had my purse stolen often, so I was poor. I lost my balance and had difficulty in walking. The social work took the kids away and put them into care - I don't know how they knew. They still like to see me. And now the eldest keeps on running away. And I lost the house." (Annie)

"A year ago the social work took the kids away - just short term. So I drank more. I can't get hold of my social worker. My husband was getting help since last may/june. He was attending Priesthill Alcohol Centre, the day centre and he asked if I could see her [the worker there] after the kids were

taken away. She was OK. I had counselling and then I went everyday, Monday to Friday."
(Annie)

"You can get your kids if you ask - unless the social work says no - they're always nosey and interfering, they can make life worse. They took my kids away behind my back after I told them I had a drink problem and now I have no access - the social worker wrote a bad character reference for me. They make things worse - I hate authority now."
(Pat)

The women I spoke to were generally well aware of the processes of social control of women, in particular, the role of health and welfare agents and the threat of sexual/physical violence. In particular, the functional definition of women as mothers as particularly effective in enforcing women's abstinence - both from collective public activities, and from alcohol. Significantly, in accordance with the wider clientele of the health and welfare services, all of the women I spoke to came from working class backgrounds, some experiencing a considerable degree of impoverishment, from which alcohol provided some temporary, illusory respite. And while the women I spoke to generally resented the coercive intervention of the health and welfare agents, feeling powerless to rebel against it, most of them welcomed the alternative respite that such 'treatment' provided.

CHAPTER 8: TREATING WOMEN

While formal health and welfare intervention in women's inabstinence must be regarded as a means of maintaining the patriarchal control of and access to women, it must also be seen as the product of reformative struggle. Drunken women themselves feel the need for some support as they caricaturise the dependency that defines contemporary women; and health and welfare workers often have a clearly critical view of the institutions describing the scope of their activities. The form of health and welfare intervention in women's drunkenness, therefore, must be regarded as the result of many and varied struggles.

Very few women that I spoke to said that they had actively chosen to start treatment for alcohol problems: several (13)' were required to 'treat' their alcohol problem in order to maintain/regain custody of their children.

"Once when I was drunk I tried to leave him, I got the children ready and left him for 6 months - I was without the youngest two and the eldest (from my first marriage) returned after 2 weeks. I went to court to get the kids and it dragged on until I decided to shelve things. I could get the kids so long as I got help and went back home. So I'm here." (Cath)

"You're threatened that your kids would be taken away from you if you didn't go [to treatment]" (Linda)

"My kid was taken away so I came down here, the social worker sent me." (Eileen)

Other women (4) were in treatment after the intervention of the police and the law courts.

"I've had eight convictions - breaches of the peace - and I was on twelve months probation. It finished last year. I had to go to West Regent Street [Glasgow Council on Alcohol] on Saturdays from two o' clock to nine instead of prison." (Frances)

"I was first picked up by the police and went of Leverndale [hospital]." (Debbie)

And other women (2) were receiving treatment after demands from their families.

"The family asked if I'd go to the doctor, the hospital, so I went." (Mary)

The women's preferences for the form of treatment varied. Some (4) preferred hospital treatment for the 'time-out' it provided from the demands and isolation of motherhood:

"The hospital is great - I've enjoyed it - you can always speak to someone." (Isa)

"You get time to think, away from the weans..." (Fiona)

"Hospital's best, it takes you out of the house (I was very lonely)." (Rose)

Other women (9) preferred hospital treatment because it enabled them to escape their environment - however briefly - and thus to stop drinking completely for a limited period of time and regain their health.

"[Hospital] was somewhere to go to avoid my alcoholic friends .. I was very nervous .. when I stopped the day care I began to booze again.. before I knew about here [Renfrew Council on Alcohol]" (Lesley)

"You get off [alcohol] for a few weeks constant, then make a go of it." (Louise)

"I felt great and looked great when I came out [of hospital]." (Eileen)

"In hospital I looked well.." (Linda)

"Doctors are good with personal problems - they're strangers.." (Jackie)

Other women (4) were concerned that they would be regarded as medically ill and subject to medical/psychiatric treatment that did nothing to resolve their problems.

"If I'm in hospital then I think that something is really wrong with me." (Ann)

"I was ill when I had to go to Leverndale [hospital]" (Jane)

"I don't like to see drinking as an illness, its just a happening.." (Rona)

"I was feart of coming out, the problems were still there.." (Fiona)

In particular, the psychoanalytic approach experienced in hospitals was disliked (7) since it forced the women to feel feelings that they drank to forget, whilst doing nothing to practically resolve their unhappiness.

"The hospital had a blackboard [and used psychoanalysis] - how can I remember how I was when my sister was born? Injections and drugs... therapy is obviously useless .. or else I wouldn't be here." (Susan)

"[Psychotherapy is] OK .. gets things up, but I'm always fearful of the outcome, of the strait-jacket - I'll never forget that at seven [years old] - remembering about [sexual] interference at 7." (Kate)

"It turns you into your self.." (Jenny)

The use of Antabuse seemed to be better favoured by some women (2), perhaps because it is something that they feel will help them to control themselves.

"I always managed to get to work - I'm on the sick just now, but I'll go back next week. The doctor was sent in because I lost the power in my legs, I didn't eat. I want antabuse. The family went away, but now they're rallying round, we'll spend more time together..."

When [my husband and I] separated 9 months ago my drinking got much worse, I spent 4 weeks in hospital. I was frightened, but now I feel pleased - the staff are good, they always listen, and the whole group of patients have got on well together. I think it's been successful.

I've been sober for 17 weeks now.." (Gill)

"I prefer antabuse - I don't trust myself, I've always gone back.." (Debbie)

Learning of the physical process of intoxication and of the consequences of prolonged consumption of alcohol made a profound impression on one woman. This is a more sophisticated means of emphasising the individual determination of alcoholic drinking, and secures abstinence on a more long term and committed basis than antabuse therapy (chapters 4 & 5).

"Before I came into hospital and dried out - I've learnt about my general health, see it's alright getting dried out from the alcohol and going to groups but they don't really train you about how your own body works and how the alcohol affects the human body - about brain cells, your blood test thing - I had no idea that alcohol could destroy your body as much as it does - even your brain cells... I was very ignorant. All you get [about health education] is about AIDS and about smoking - why don't we get [health education] about alcohol?" (Helen)

More social treatment modalities, however, were preferred by most (16) of the women that I spoke to. Group therapy, in particular, seemed to be favoured, either alone or in combination with other modes of treatment. Group therapy seemed to be significantly important in providing a sense of 'belonging', of social identity and of friendship which the women had not experienced elsewhere - drunk or sober, in treatment or not.

"I will continue [to go to groups], I have to Sheila - because you're apt to forget. Its

hard all the time. It's hard for me because I usually get way down Friday [I miss the programme at Gartnaval]. I used to have maybe 2 bottles of vodka [on a Friday] - I was a drug addict, I had to have it because I was shaking and ...

The groups here help, because I've found that I wasn't alone - self-consciousness, the shaking, the nervousness, the depression, it's made me think about it. You know you may go outside and speak to someone that you don't know and inside they're just the same as you - maybe uptight.." (Helen)

"In the group I was embarrassed at first, scared of being different.." (Joanne)

"You see yourself in other people.." (Jean)

"It feels good if I tell others, it feels good because I'm not hiding it, as good as if I say no to booze. I'm helping myself.." (Ann)

"If I can tell someone things .. then I feel good. But not if someone tells me, talks down to me or is too severe [distanced]." (Christine)

"Groups like this are a lot of support.." (Fiona)

"The people are very nice, the workers tell you the truth, they're straight with you.." (Rose)

"In groups you can practice mixing.." (Louise)

"I went for help and now I don't see my drinking friends. I avoid drunkenness and social drinking. I was ashamed at first but now I'm committed to the group, it helps to talk to others, it gives understanding of others. I'm proud of myself now. I had to prove to my friends that its OK not to drink." (Agnes)

".. the group is a different kind of friendship - not everyday social friends.." (Joanne)

" .. others outside the group never say 'Well Done'.." (Nicky)

"I feel heard here.." (Lesley)

"You can complain in the group.." (Nicky)

"Nothing would stop me coming here, not even John [husband]." (Diane)

Group work, therefore, provided the women with a sense of social legitimacy. They found friends, women of who they were initially scared, expecting judgement. Most of the women (15) had been to Alcoholics Anonymous meetings at one time or other in their drinking career, either as part of their formal treatment, or on a more voluntary basis. Some women (5) liked the group approach of AA meetings, others (9) found the approach more oppressive.

"Its a good thing in knowing that you're not unique with the problem.." (Kate)

"I went to AA 5 years ago. I was at my worst - slit wrists and things. I'd heard about it through the social work. I liked the people, but not the discussions - I'm a private person." (Debbie)

"I think AA meetings sometimes make things worse - they're too melodramatic." (Isa)

"AA's no good, I feel under pressure to talk - and I had to bring the kids. It was all pressure.." (Joanne)

"Its not on to say I'm Pat and I'm an alkie.." (Pat)

"You meet other members out for messages and think that they've told others.." (Alison)

The characteristics of AA that the women disliked seemed to be in common with the aspects of group therapy that they disliked: an exclusive focus on alcohol, and definition of self in terms of alcohol; discussion of 'private' things with virtual strangers, especially men, childcare problems and anxiety about the stigma of treatment for alcoholism.

The size of a group seemed to be particularly important, with some women (3) feeling inhibited in large groups:

"The big groups [more than twenty people] are awful - the size of a group is more important than the sex.." (Kathy)

Some women (4) felt vulnerable talking about themselves in front of strangers:

"I'm fearful of what people think of me, so I prefer to talk singly - and you can get that anytime here, including with the residents.." (Susan)

"It's scary, I prefer people not to know.." (Diane)

"People here know too much of other peoples business.." (Mary)

Knowing the group members helped some women overcome their fear:

"I like to know who will be there.." (Diane)

And other women (4) felt that a combination of group work and individual counselling helped women overcome the initial fears of talking openly in a group of strangers.

"A lot of talking helps - people don't always share personal problems so they mix group and single therapy, if you don't want to talk you don't have to." (Susan)

"I prefer group to individual, it's more help than individual counselling, but you need to see the individual at first." (Agnes)

Several (6) of the women that I spoke to preferred women-only groups:

"I can talk in front of women but not men - maybe individual sessions would be best.." (Diane)

"I feel more at ease with women, small groups.." (Joanne)

"I only like Tuesdays [women-only day] here.." (Lesley)

"The women's group is good - the first group I went to was eight or nine men and me and I didn't speak. I thought that the men judged me because men don't take care of kids - men don't want to listen to problems, but we care about them.." (Diane)

Children not only seemed to be a major problem in terms of women feelings of being judged by men, but also in two other related respects: firstly the social role of mother allowed for no time-off, no relaxation; and secondly in terms of treatment intervention (chapter 7). Sharing treatment with

men, however, was not always regarded as a negative thing by the women:

".. you learn how to relate to men." (Kate)

"..it's OK, some men give good advice."
(Rose)

Several women (6) felt that although there was more of a stigma attached to treatment than to drinking and drunkenness, mixed treatment modalities had less of a stigma than women-only modes:

"Treatment with men isn't stigmatised..
(Jackie)

Most (14) of the women that I spoke to were acutely aware of the stigma attached to alcoholism treatment.

"Everyone gets to know if I have even one drink - they're suspicious and you're not trusted so you learn not to trust yourself - you're always explaining, excusing yourself.." (Susan)

"You're condemned, uncomfortable, abnormal, you loose credibility." (Jenny)

"I wouldn't tell anyone [that I was coming here], now I'm OK.." (Fiona)

"You can suss out other people with alcohol problems - its something with the eyes - they're dull, sad, gazey. Drug addicts have deep eyes ... will I always look like and alkie, even if I'm sober?" (Rona)

Despite this, however, they generally felt that they were benefiting from the treatment (20) and

were anxious about life 'after treatment'(12). The crux of the women's fear of the end of their treatment programme was in the return to the life circumstances from which they drank to escape: abstinence from meaningful and productive activity and their consequent social isolation; and also their denial of effective means of relaxation or 'time-out'.

"But I like it here - I'm worried about the end of the six weeks, then I'll be back in the house, lonely, isolated. All my pals drink.." (Christine)

"In here the people are all the same, they're all boozers. The staff are good and it occupies the day. Here you can talk about overcoming the drink - fulfil something. There are good things now, but I'm fearful of the end.." (Debbie)

"I don't want to go back to the same [drinking] environment, I don't want to drink again - my neighbours do.." (Annie)

"My second husband is now in a rehabilitation centre in Paisley. I get on well with him - he comes here at the weekend. I hope that we will get a home together, but in a different place, not where drink is involved." (Annie)

"There's no alternatives to alcohol - except maybe sport - sport helps you relax and gives you a routine.." (Pat)

"I'[ll] have to train myself to sit and relax and watch the television without a glass in my hand - I used to do a lot of knitting, so I'm going to buy a ball of wool.." (Helen)

"You need a job, something to occupy your mind .. to meet people and mix.." (Eileen)

"My social worker's arranged a voluntary job to get [me] out of the house, and someone to get the wean to school.." (Linda)

"I'll maybe do voluntary work.." (Isa)

"There's one friend that I've made in here who takes AA groups and she said 'once you get discharged from here how would you like to be on call - that is if, say there's a woman rings up during the night and she needs help - someone'll come and pick you up and go to her house and talk to her' - which'll help me, because it keeps reminding me of how I used to be - and I'm also helping the person that I've got to speak to." (Helen)

A particular problem that the women (5) were anxious about on completing their treatment programmes was that of their husbands accepting them:

"It was OK at home at first but now it's terrible - my man has only seen me drunk really - I met him when I was drunk - 13 years ago. It's as if he wants me, but not the way I am - not letting him dominate me. I can see things clearer now, he doesn't like it, he takes money from me so that I can only have shopping money. I have to give my sickness benefit to him. There's no trust - he's putting me back to where I was 5 years ago.." (Cath)

Insofar as treatment is effective in encouraging women to take control of their lives, to engage in meaningful activity and to find pleasure, it provides a more potent means of challenging women's functional (abstinent) role than drunkenness. In doing so, it challenges men's access to women as a means of patriarchal

expression and pleasure. At an individual level, some (3) of the women that I spoke to encountered the hostility/violence of their husbands as they soberly refused to abstain from waged work, leisure and sociable solidarity with other women. I contend that this is the major problem facing inabstinent drunken women who are attempting to begin inabstinent sober lives.

Much treatment of inabstinent women, however, is not primarily in terms of achieving control over their lives. Some workers (5) that I spoke to felt that the women's general health and well-being would follow once she stopped drinking: treatment in these cases was simply in terms of ensuring the woman's abstinence.

"A lot of them want to be social drinkers - well, a lot of the people that we're seeing realistically can't be social drinkers because they've been drinking vast amounts for years and they just can't control their drinking to such an amount that they can lead a normal life again with drinking. So therefore we - well I - tend to see .. total abstinence as the only way they're gonnae beat the problem that they've got .. but you need total co-operation with them you know.." (male worker)

Such treatment modalities based upon total abstinence from alcohol, however, tended to be relatively unpopular as they are premised upon the

disease concept of alcoholism. Several workers (14) explicitly rejected the disease concept of alcoholism - some (2) because it was simply 'old fashioned':

"It's semantics. I mean the category isn't 'Alcoholic'. The kind of data-sheet you fill in now is 'Alcohol Dependence Syndrome'. The term alcoholic was expunged about 4 years ago." (female worker)

But more (8) considered that 'alcoholism' was less an illness than a response to aversive life situations, and that to treat alcoholism as a disease exacerbated the problem.

"I wouldn't say it was an illness at all - a response to people's situation, I would reckon.." (female worker)

"The way we look at it is you have an alcohol problem which you want to recover from, but there's no reason why you can't fully recover from it. But it involves a change, quite a dramatic change in yourself in order to achieve that. But there's no way that we feel that alcoholism is an illness or a stigma that's attached to people - we see it as a response .. a behavioural response to a vast number of different things... Basically what, what we want, or what a client coming here wants to achieve is not going back to the premorbid state, like the way they were before they became a drinker, because that led them to become a drinker. They have to change. Drink should cease to be important in their life. We live in a society where drink's round about us all the time, and we're not going to get rid of that. So that somebody who's had an alcohol problem has to learn how to be able to function in an alcohol saturated environment and feel comfortable in it, the way I feel comfortable. Not feeling at risk. But having

said that, after a few weeks at this clinic we don't tend to talk about alcohol so much. We tend to look at any underlying problems, and look at ways of identifying problems, expressing your feelings, recognizing how you feel - because some people seem to find that difficult. And then finding ways of dealing with problems. Practical ways of dealing with problems rather than drinking which has been the response in the past." (male worker)

In particular, some workers (7) felt that the disease concept led to the stigmatised stereotype of the 'alcoholic', which led to delayed detection of harmful drinking and the 'telescoping' of problems.

"Well personally I don't know what an alcoholic is. I've worked in this field for over 5 years and I've yet to hear an accepted definition of what an alcoholic is. I think it's a rather useless, empty word, so we don't use it in this clinic, we talk about problem drinkers, and what we tend to focus on is the problems that have been caused in the peoples' lives with their drinking rather than the actual amounts of their drinking. We try to discourage people from looking at themselves as an alcoholic. I think alcoholic is a bad word because the general public know this word and they see an alcoholic as someone who's homeless, maybe drinking surgical spirits, so the average person in the street says 'well that's no' me, so I can't be an alcoholic', but they're actually drinking one hell of a lot of booze. I think most people with drink problems are ordinary people going out to work each day and doing their own thing. It's roughly 9% of the heavy drinking population who are the classic homeless people, so that leaves you 90% of people with alcohol problems who are not living like that, who are not homeless and not drinking surgical spirits. That's the one that catches the headlines..." (female worker)

"I don't believe in the word alcoholic. I hate it. I don't believe that there's such a thing in terms of the popular myth and I think there's all sorts of nonsense going around about alcoholics. Well .. there's the popular myth of what an alcoholic is - a lot of people who are perhaps overdrinking don't identify with that image: 'I'm not like that therefore I don't need to do anything about it'... I think it's terrible to put labels like that on people as well - the whole thing about relapse and the idea that one drink is one drunk and that's you. I think that also the whole stereotype and the stigma that is attached to people with alcohol problems." (female worker)

Furthermore, to treat people who seem to be 'problem drinkers' as 'alcoholics' and to focus exclusively on alcohol as 'the problem' is seen as some (4) workers to create a self-fulfilling prophecy:

"I think there's a big difference to the person that you're sticking the label on. I never use the word 'alcoholic', except if its an adjective - alcoholic drink - I never use that term." (female worker)

"I don't like the label 'alcoholic', can I say that. I use it: I'd use it in this context and I'd use it in a training context, but I'd never use it when I'm with somebody who has an alcohol problem, unless I use it in a very specific way, because I think having used the term 'alcoholic' then that gives the wrong sense of status. And I think that, very often .. the person - one of the things they're looking for is a sense of status. I think that we give them the wrong one if we give them the label 'alcoholic'." (male worker)

Most workers (16), therefore, felt that the treatment of inabstinent women should take

cognisance of factors other than alcohol. Some (2) felt that such women required feminine rehabilitation.

".. the female patients .. benefit from relaxation, cookery sessions, knitting classes, things like that - things that're geared more for their needs." (female worker)

Other workers (3) felt that many drunken women needed rehabilitation following early incestuous abuse and/or more recent sexual violence. Whilst this recognizes the significance of patriarchal consumption in the development of alcohol problems, all of the workers concerned with women's experience of male violence felt that such women needed to learn how to relate to 'normal' men in order to 'recover'. The treatment emphasis, therefore, was on working in mixed groups and/or with a male counsellor.

"Quite often we've found, to give you an extreme example, that a lot of women drinkers who call in here have problems of incest.. they actually prefer speaking to a man." (male worker)

"Being a counselling service, sometimes when women come and they say 'well, I've got a difficulty, you know I'd really like to see a woman, I'd rather not see a man', that's an indication of where the problem might lie and therefore sometimes we'd maybe suggest - maybe not the first interview - we'd maybe suggest that the appropriate thing is, in fact, that they're seen by a man." (male worker)

"We have some clients here who've suffered sexual abuse at the hands of their father in the early years... I would say it's probably a precipitating factor: it would be much more difficult to find out whether or not that was 'The Cause'. In cases like that .. we try to resolve it within the [mixed] group. Coming from what I've heard from clients - female clients - they say that men tend to be a bit more gentle in their approach and females a bit more brazen, brutal about it, if you like.." (male worker)

I think that it is significant that those workers advocating that women who have been violently consumed by men should be 'treated' by male workers are all men themselves. I also think that it is significant that all (5) of the workers with this view argue that it is the women themselves who prefer to work with men.

"Yes. I think that woman patients, female patients prefer male workers and vice versa. I think its from the empathy point of view. I think, I don't know, but male seem to relate more to females - I don't think males like talking to males - because of the macho aspect - but we - I - find in here that a lot of the females prefer talking to men and men to females - they talk easier to the opposite sex." (male worker)

These workers views run directly contrary to my discussion with drunken women, who tended to feel much more at ease with women worker and in women-only groups. One male worker gives an indication of the reasons for the preference for the treatment of women with men;

"My own opinion is that mixed groups are better - because women can learn from the men and men can learn from the women. I think when you start making it a closed group, for men only - OK it's good, don't get me wrong, but the fact is I think the women's views are worth listening to as well because on many occasions blokes're wondering how their wives are - and if the women're there they can talk to them.

I'll mention this, when you get women and men together it's good, because guys listen to a woman, you know you get a lot of good.

There's just as many good woman speakers as there is men. I know that because I've listened to some of the women and they are good." (male worker)

In his patronage of women, this worker suggests that women in treatment should be a means of masculine recovery. And the rehabilitative treatment of inabstinent women, I suggest, can be seen as a means of the perpetuation of men's access to women as a means of masculine expression.

Some workers, however, felt that it was important that women rather than men workers treat drunken women (12), and also that women-only facilities are provided (9).

"I think that a woman can identify more with another woman." (male worker)

The workers arguments for women-only treatment were based on three general assumptions: firstly that the essential differences between women and

men meant that men could not identify/empathise with women (6); secondly that the socially constructed ('ideological'?) differences between women and men meant that men could not identify/empathise with women (10); and finally that the social structural differences between women and men meant that women-only facilities threatened men's necessary access to women (5). Interestingly, of those workers contending that there are essential differences between women and men, 5 were men and 1 was a woman. These workers also tended to believe that drunken women were more pathological and incorrigible than drunken men (chapter 7). Similarly, more men (7) than women (3) held that the socially constructed ('ideological'?) differences between women and men meant that men could not identify/empathise with drunken women. And significantly, all of the workers who were concerned with the social structural differences between women and men were women.

Those workers who held the first assumption - of women's essential difference - sexualised the client-counsellor relationship:

"Well there always is .. a sexual element - and I think that one would acknowledge that there is a level at which human nature'll always make it that they will treat sexes differently. But we try in as much as possible to work with the whole person who has appeared and not allow that to cut across the work." (male worker)

Despite the essential difference, therefore, there was the hope that professionalism would enable men to work effectively with women; that professional training would 'de-genderise' the therapeutic relationship. This hope was also evident with those workers who thought that the 'ideological' differences between women and men would dissolve in the face of professional training.

"I used to wonder if perhaps there was a risk of a female client feeling judged by a female counsellor, or perhaps even comparing herself to the female counsellor and seeing the female counsellor as somebody who's made a success of her life - you know, well turned out, articulate, the rest of it - and sort of being undermined by that, but then it may well be that some female counsellors are more sensitive to the problems that women are experiencing - but I would hope that, in as far as we try and address these problems in training then male counsellors could be." (female worker)

Problem drinking from this perspective, therefore was seen as gender neutral, subject to individual rather than structural factors; and training was regarded as the means of developing an objective and individual-centred approach to the problem drinking client/patient.

"Well, I would answer that question by saying that any kind of therapy that's going to be of any value has to be client oriented. I would say that every male had different specific needs - and every woman as well."
(male worker)

".. remember we're a counselling agency, so our *modus operandi*'s counselling - I think that different problems'll come out for different individuals, whether they're male or female, and that those problems have got to be looked at. The problems that come out for women will, in some ways, be different from those of men, but the treatment will be the same as far as counselling's concerned."
(male worker)

"Overall .. I think all people with alcohol problems have specific problems which I think're specific to them - I don't see people with alcohol problems as people that you can just lump together. Whether it's male or female, they're all individual with individual problems. So .. we treat everyone as an individual..." (female worker)

Training, therefore, was regarded as more important in determining the success of the therapeutic relationship than the workers identity as a woman or a man, or as a recovering alcoholic or a non-alcoholic. The professional approach rendered such subjective factors irrelevant.

"I think some specialised training is extremely helpful - partly because people get very disheartened working with drinkers and I think if you've got some specialist training you'll not be surprised at relapse .. that kind of acceptance is helpful to have. I think its also helpful if people are aware that drink problems overlap all sorts of things - mimics depression, mimics anxiety .." (female worker)

"I don't think anybody can come in and counsel people - they need training. I think that recovered alcoholics can be helpful - equally without training they can be extremely dangerous." (female worker)

For these workers (10), specific professional membership was more important in effecting 'treatment outcome' than either worker or client characteristics.

"I think different professionals treat problem drinkers differently. I mean social workers would treat them differently from nurses - the social workers perspective is generally family oriented, the nurses is on the individual - the sick individual, it's not family, it's not society, it's all individuals that've got diseases, they're ill and you treat them. I think profession is more significant than the gender of the counsellor, counsellor's are just human beings themselves." (male worker)

Other workers, however, felt that professional training was less important than whether or not the worker was a woman or had experienced problems similar to their clients/patients.

"I think my basic life experience has been more helpful to me than my specialised addiction experience. That's very subjective, but I honestly believe that." (female worker)

"I feel that you have to be able to at least empathise .. you have to be able to identify maybe something of [your clients] in you, or something of yourself in them if you're going to be able to do anything useful." (male worker)

".. one is aware of one's own potential, particularly with regards to alcohol. I started drinking heavily, but I actually saw what was happening before it got too far,

so in that sense I can realise that I have the potential that my clients have, and in fact I think that we all have that potential, given their situation. So I'm aware of that, and I think it is important and it's something that having really does affect your attitude when dealing with people." (male worker)

Of those workers who felt that their subjective identification with their clients/patients was important, some (7) tended to argue for individual special needs while others (7) felt that the structural similarity of women workers with their women clients was particularly significant.

"I have some of the problems [that my clients have] - especially some of the women: depression, anxiety.." (female worker)

"The problems are all the same [for women].." (female worker)

In particular, these (7) workers noted the enforced abstinence of women's functional role.

".. they've gone through life depending on a bloke - [women need] to be able to build, to make their own decisions." (female worker)

"[Treatment must recognize women's] domestic responsibilities, whether that be children or the elderly - for them just to get to treatment can cause problems - creches, baby care, or elderly care - whatever you want to put, whatever they want to put - quite often it's elderly parents, or the disabled, or the mentally handicapped. They're confined by their children - the times that children are at school, that will define them.." (female worker)

"I think the other difficulty of course, for women, is .. [that] the mother is left with the child ... I mean there's a whole area

then of problems associated with being a mother and the entrapment of being young with a child around your neck. And all those issues come into play." (male worker)

"[Women need to] do something for themselves because they're still putting the kids first, whereas the men who come here can attack their drinking problem head on because of not having to worry about their other responsibilities." (male worker)

Women's structural dependence on men was seen as limiting the possibility of their gaining sober control of their lives. In particular, women's domestic responsibilities, particularly for children deprived them of the possibility of participating in alcohol treatment of their own volition: the lack of childcare facilities at treatment agencies and the timing of group and individual provision outwith school hours meant that it was often impossible for them to seek advice on alcohol (or other) problems; and further, insofar as women's inabstinence was regarded as detrimental to their ability to 'mother', the intervention of social welfare agents enforced their treatment. Either way women had no control over either their sobriety or their drunkenness.

".. most of our women clients .. have been referred to us by the social work department. It's very rare for a woman to walk in off the street.." (male worker)

".. they're referred to us by social workers .. and often the reason for referral is that they're having difficulty caring for their children. Their children're maybe in care or about to be taken into care." (female worker)

One of the workers that I spoke to related women's functional role and limited control over their lives explicitly to their low self-esteem:

"A woman's self esteem and her view of herself as somebody who's become vulnerable to alcohol is likely to be much more

seriously damaged I'd say than it would with a man. A man can much more readily externalise the problem - OK so he's developed this pattern of problem drinking - but it's because of the boss, it's because of financial worries *et cetera*, whereas a woman is much more likely to say to herself it's because of me, it's because of my own inadequacies that I'm having these problems. And that possibly explains why she's more likely to present at a generalist agency rather than an alcohol treatment agency. You know, because she feels personally that agency might more readily take on board .. something to do with her anxiety problem, emotional difficulties, personality difficulties. So given the serious risks to self image and self esteem .. the process of helping somebody towards recovery, I think, has got to take these problems and those needs into account .. you know they've got to be addressed by the person who's helping... I think that if a specialist counselling service can be fronted by a sort of generalised door then that would be helpful and if the problems that women experience in terms of getting access to agencies can be resolved by providing through-the-day care and giving support through pressures *et cetera*. If these problems can be addressed and looked at, then I think that would help and awful lot too." (female worker)

The sanctioning stigma attached to inabstinent women was seen by several workers (6) as a major problem for the women that they saw.

"The other problem is about the stigmatisation, the value judgements that're put on women that have alcohol problems - value judgements that they put on themselves. And the female clients are more readily defined as having an alcohol problem, even though very often I would say in most of our women it's preceding problems .. domestic violence which they've suffered as children and as an adult. Sexual abuse in rape. Mental health problems. Low self-esteem." (female worker)

"I think there's certain characteristics which I think women have such as they suffer .. more stigma than men, but I wouldn't say that men don't suffer stigma - from being labelled alcoholic or whatever. But I think that for women its slightly more of a stigma - and it might slightly be harder for women to acknowledge that they've got an alcohol problem because of the stigma." (female worker)

"I mean you can't say that everybody's the same - women .. have been more damaged - like the prejudices in society of women that drink are worse, and for women who're homeless they're worse as well - there's a lot more stigma." (female worker)

Thus, due to the structural differences between the experience of women and men, most workers (13) felt that women-only treatment, in particular group work, was important in treating inabstinent women.

"[In mixed groups] women feel they're being pushed aside or being spoken over or being interrupted - maybe even being judged and labelled by a man in a group ... You know women can get a lot of support from other women through understanding that things that they think are peculiar to them are actually problems which a lot of women have in common." (female worker)

"I think we've all got to acknowledge that - even though [workers] might think that a male worker could be very understanding, that doesn't mean that the [woman] client'll feel it like that." (female worker)

"[Woman clients] need more certainly in terms of their self respect - I think a lot of the services that're geared towards helping people with alcohol problems don't recognize that - it's all very macho.." (female worker)

"There seems to be a need for group services - our group service for women is going quite well - it's gone beyond a counselling group - it's almost turned into a social group - we'd expect that anyway - it's quite a long running group .. In many instances women need social skills training - definitely need social skills, confidence building, relaxation training, assertiveness.." (male worker)

"When a woman gets involved with drugs its not because she's incapable of expressing her feelings - of self-respect - it's trying to build that up .. I certainly find that one has had a greater struggle with .. getting them .. to actually review themselves as being not nasty pieces of work - but really human beings.

... we've just had a group on Friday .. just purely a group looking at how the week had gone, but the women were beginning to bring up problems, and .. I was trying to point out to them that they had a lot of positivity - they find it difficult to believe it - and putting them in touch with that positivity, saying 'look you've got these skills' .. to give them back balance. I'm not talking about drugs at all. So it's about getting them to get themselves back in perspective - and regain respect for themselves not only as mothers, but as women, as human beings." (male worker)

The issue of alcohol was seen as a minor aspect of the discussions of women-only groups, the focus being upon the women beginning to value themselves and to take control of their lives. However, some workers (7), like the drunken women that I spoke to, identified problems in women maintaining their self-worth and control in the face of the demands of patriarchal society.

".. can they come here [to group work sessions] - will their husbands let them? Very often they're in a marriage [where] - and this creates many problems - they're still looked on as being the possession of men. They're timewatched, they're c lockwatched when - if - they go. The problem of going out at night - the women that we see live in areas, as a great many areas in Glasgow are, that've got poor transport, badly lit. And there's the real problem that they daren't go out late at night... There's not a lot of women that come to these groups - for very practical reasons again."
(female worker)

These workers identified men's active retaliation against women's (sober) inabstinence in meeting socially with other women: the threat of attack in being out at night without a man, husbands preventing women from attending group work sessions and alcoholic men in treatment disrupting women-only space and time.

"[Women] are much more open in women's groups, they don't feel so threatened... And the problems we had trying to keep this Tuesday afternoon [women-only time] free of men - they actually ganged together, they did everything possible to disrupt this group."
(female worker)

And further, once women actually completed their treatment, there were problems in maintaining the degree of self-worth, life control and solidarity with other women that they had achieved.

"There's also the other problem about them going on to do any development work themselves, outside, in the community.."
(female worker)

"[There is] no access to being able to develop their own skills either in the community or in employment." (female worker)

The possibility of women's sober inabstinence, in terms of their active pursuit of pleasurable and public activities is inhibited, therefore, not simply through their "self-destructive" caricaturising of the organic construction of dependent femininity in alcoholic drinking; but socially and materially. The women whom I spoke to, although administratively defined as deviants, expressed the parameters of the social control of any female inabstinence. So long as women remain dependent, in economic and emotional terms, on an individual and a social level, their activities will remain approved. When a woman begins to engage in independent activities, in a domestic or a public arena, she will begin to experience penalties - the loss of her children, the risk of violence or harm - that cut across the boundaries of the economic and emotional, the private and the public.

CONCLUSION

In researching drunken women, the processes of the social control of women as it occurs through the construction of femininity as abstinent - in particular, femininity as abstinent from public, productive labour and also from the active/public expression of desire/pleasure have become evident. My general thesis is that although women's inabstinence in both of these spheres provides a threat to patriarchal stability, women's *drunken* inabstinence provides only an temporary, individualised and sometimes self-destructive omen of the threat. My contention is that the characteristics of femininity itself are 'drunken' insofar as they demand dependency, patriarchal accessibility and a dislocation from public/productive activity. Thus when women seek relaxation, pleasure or escape through drinking, they usually find themselves caricaturing the sexualised dependency that defines femininity; and almost always find themselves censured for such inabstinence in terms of that caricature. An examination of the processes of the control of

drunken women explicate the processes of the social control of all women in terms of the containment and privatisation of their active collective pursuit of pleasure.

The possibility of women's sober inabstinence, in terms of their active pursuit of pleasurable and public activities is inhibited socially and materially. The women with whom I spoke, although administratively defined as deviants, expressed the parameters of the social control of any female inabstinence. So long as women remain dependent, in economic and emotional terms, on an individual and a social level, their activities will remain approved. When a woman begins to engage in independent activities, in a domestic or a public arena, she will begin to experience penalties - the loss of her children, the risk of violence or harm - that cut across the boundaries of the economic and emotional, the private and the public.

Working class women, in particular, lacking the material distancing from public scrutiny that wealthier women possess, are subject to public

health and welfare intervention in their inabstinence. The detached houses and gardens, husbands who can afford private child-care and house-keeping to compensate for their wives inabstinence, and private forms of feminine rehabilitation mean that middle-class women are largely absent from drug and alcohol agency clientele. Within my field work, middle class women were noticeably absent. I would suggest, however that inabstinent middle class women (drunk or sober) are likely to experience forms of control, the difference being, however, that such privatised controls are more implicit, and possibly more internalised than those effected through public health and welfare intervention.

My field work, in focusing on the experiences of working class drunken women, demonstrated some material implications of the enforcement of women's abstinence: 27 out of the 33 women with whom I spoke related their drinking to enforced abstinence, especially the compulsions of their marital role. Seventeen of these women said explicitly that they sought 'time-out' from those compulsions, or pleasure through their drinking.

However, they were all aware of censure of their drinking through the threat (often experienced) of sexual violence. Almost of the women with whom I spoke felt that women were not liberated in the late twentieth century. Among the agency workers, however, the influence of the organic analogy was such that half of the people with whom I spoke felt that drunkenness was 'unnatural' in women, and that the contemporary equal opportunities movement (rhetoric) pushed women into unnatural and unhealthy habits, such as drunkenness: drunkenness is the ransom of emancipation. Very significantly, of the ten (out of 20) workers expressing this view, eight were men. The alternative view, that women's drunkenness was related in some way to their oppression within a society stressing organic statuses and the natural feminine role, was held by the remaining ten workers, predominantly women (8). In accordance with the views of their clients, these workers identified the enforced abstinence of women, particularly through marriage as of central importance in the construction of their clients as deviant inabstinent.

With regard to treatment possibilities, most of the workers with whom I spoke (16) felt that recognition of other factors than alcohol was important. Interestingly, the issue of the rehabilitation of women was focused on the reinforcement of the importance of developing 'normal' relationships with men: eight workers, all men, felt that drunken women, therefore, should have male counsellors and experience mixed, rather than women-only groups. A slight majority of workers (13), however, felt that women only treatment was more beneficial. Of these workers, gender again was significant: 8 were women, 5 men. Furthermore, when I asked these workers to explain their views, 6 accounted for the benefits of women in terms of essential sex differences, 5 of whom were men, 1 being a woman; 11 identified ideological gender differences as being the key - 7 men and 3 women; and 7 workers were explicitly concerned with social structural/material issues as effecting treatment, 5 women and 2 men. Only this latter category concurred with the experiences of the drunken women with whom I spoke: of a total of 33 women, 18 were legally compelled to be in treatment for their

inabstinence: 13 in order to maintain or regain custody of their children, 4 through the criminal justice system. None of the women with whom I spoke said that they preferred or needed a male counsellor or the opportunity to participate only in mixed treatment modalities: 13 explicitly preferred women only treatment. Most of the women (20) with who I spoke felt that they were benefiting from their treatment, however, most of them (13) were anxious about the end of their treatment, feeling that a return to their functional abstinent role would inspire them only to resume their drinking, and fearing that any expression of sober inabstinence - such as seeking employment or education, or choosing to be single rather than married, would incur even more unpleasant sanctions.

Consequently, to define treatment as successful only in terms of women successful conformity to the abstinent role of the organic mother is to amplify the women's risks of misplaced inabstinence. In struggling against the strictures of their functional role, women seeking respite in alcohol are subject to physical and sexual harm,

to measures of feminine rehabilitation which intensify their oppression. 'Treatment', therefore must seek to enable women to engage in soberly inabstinent activities - to become expressly independent (of patriarchal control) in domestic and/or public arenas; and further to facilitate women's development of collective means of support and pleasure in order that they can survive patriarchal sanction. Thus 'treatment' must become overtly political, insofar as it addresses the issue of social change.

Drunken women, therefore, express their criticism of patriarchal society on an individual and ultimately self-destructive level: they express a germ of a threat to patriarchal society, their drunkenness however is re-enforced in their feminine rehabilitation. The patriarchal enforcement of women's abstinence finds it's most explicit expression in the treatment of drunken women, however the containment and privatisation of women's active collective pursuit of pleasure remains all women's experience of patriarchal society. *The threat to patriarchy lies in the women's passionate collective refusal to abstain*

from pleasurable activity. Drunkenness, insofar as it amplifies women's experience of abstinent femininity provides no threat and no possibility for the women's collective development of means of pleasure.

NOTES

Chapter 1

1. Throughout my thesis, my use of gendered terms is intended to be specific rather than generic
2. The philanthropic contribution to social welfare was the early precursor of the state provision of social welfare through taxation.
3. I use the term 'non-productive' here to refer to those individual who are only engaged in reproductive activities. My use of the term is specifically within the parameters of the liberalist discourse that I am discussing.
4. It is important to note here that 'traditional' gendered forms of work change historically, for example clerical work had changed from being a 'traditionally' masculine form of waged labour, to a 'traditionally' feminine form of waged labour. (Braverman 1974).
5. Again I am making use of a term specifically within the context of the liberal economic discourse. 'Value', here is specific to that which is generative of capital/profit.
6. My use of the term 'ideological' here is intended to indicate my contention that the distinction between production and distribution is false - a functionally necessary illusion in order to maintain the liberal capitalist principles.
7. The notion that inabstinent women, especially in the form of drinking mothers, are a national menace has continued throughout the twentieth century. Several late twentieth century researchers have noted the correlation between women's drinking and gynaecological disorders (Wilsnack 1973b, 1976, Kinsey 1966) and between maternal drinking and congenital abnormality (Plant 1980); and further, several researchers have suggested that alcoholism is genetically transmitted (Swinson 1980, Winokur 1969, Schuckitt 1983, Mendelson & Mello 1979, Gomberg 1979).

Chapter 2

1. Again I use 'he' deliberately: psychiatric 'expertise' in women's deviance was largely developed by men and in the interests of men Ehrenreich & English (1973, 1979)

2. My use of the term 'ideological' here is intended to indicate that Expert definitions were as effective as physical confinement in controlling/distancing deviants.

3. Again, my use of the term 'productive' is specifically within the parameters of the liberal discourse that I am discussing. I use it to refer to individuals who are engaged in the direct production of surplus value/profit/capital.

4. Lombroso & Ferrero (1895) observed that the prostitute conformed quite closely to their definition of the requisite number of retrogressive characteristics indicative of atavatism. And not only did they see the prostitute herself as degenerate, they regarded prostitution *per se* as representative of widescale atavatism or social degeneracy. Their tautological argument was that all primitive women are prostitutes (as marked by their virile sexual appetite and fecundity) and therefore all prostitutes are primitive. It is of particular relevance to my discussion that Lombroso & Ferrero compared the inabstinence of the prostitute unfavourably with the supposed abstinence of upper and middle class women.

5. See my later discussion on sex-role confusion and alcoholism; and also chapter 5 for my discussion of late twentieth century views of alcoholism as the ransom of emancipation.

6. Freud was impressed by Karl Abraham's analysis of the strivings of women for productive, publicly meaningful activity as the expression of a "masculinity complex" in neurotic women. Abraham saw feminists as

"... women who sublimated their wish to be men by following masculine pursuits of an intellectual and professional nature" (Showalter 1987).

Freud accepted Abraham's view on feminists, and his frequent "digs" at feminists demonstrates his own belief that women are essentially passive:

".. the feminist demand for equal rights for the sexes does not take us far, for the morphological distinction is bound to find expression in differences of psychic development" (Freud quoted in Wilson 1987)

"For the ladies, whenever some comparison seemed to turn out unfavourable to their sex, we were able to utter a suspicion that we, the male analysts, had been unable to overcome certain deep-rooted prejudices against what was feminine, and that this was being paid for in the partiality of our researchers. We, on the other hand, had no difficulty in avoiding impoliteness. We only had to say 'This doesn't apply to you. You're the exception, on this point you're more masculine than feminine' (Freud, quoted in Wilson 1987).

7. See also Irigaray 1973, Moi 1985, Benjamin 1973, Brecht 1975 on mimicry. Such a tactic may provide some possibility for political action, however, like women's "non-descriptness" (Worrall 1990) - failure to 'fit' the administrative categories of health and welfare agents (including sociologists) (chapter 5 & 6), it is likely to occur in individual, isolated and sometimes self-destructive forms, such as "dementia" (Irigaray 1973).

8. Maris (1971), in an in-depth study of women who had attempted suicide, concluded that most suicide attempts are, in fact, self-preservative rather than self-destructive. He argues that the suicide attempt represents a plea to society for acknowledgement, recognition and release from stigmatisation. Therefore, suicide attempts by women alcoholics from a psychoanalytic perspective do not accord with Menningers thesis of self-destruction.

9. The drinking context being the pub, which assumes mature masculine participation in rational productive activity (chapters 1 & 5).

10. Women - girlfriends, wives, mothers - often actually provide the care and comfort that the male alcoholic craves: drunkenness/alcoholism enables him to adopt the sick role which justifies and legitimates male dependency (chapter 5) (Auld, McRobbie).

11. For example Maccoby & Jacklin 1974, and Hoffman-Bustamante 1973 with regard to deviance.

12. Note also the long psychiatric tradition of taking women as the main focus of clinical research (Smart 1976), and also that more women than men become psychiatric patients (Gove & Tudor 1973, Chesler 1974, Cooperstock 1977, Smart): see chapter 5.

Chapter 3

1. In discussing the problems of positively establishing causal relationships, Saunders (1980) pointed out that it is a statistical fact that those areas with the highest birth rate also have the highest number of storks nests: the birth rate is thus strongly positively correlated with the incidence of storks. However, this statistical fact is simply interesting; it does not in itself imply that there is a causal relationship between storks and babies.

2. Although this is not to say that those individuals who have the most money will become the most alcoholic (chapter 4).

3. Antabuse (the brand name of disulfiram) therapy provides a powerful deterrent to drinking: it is a drug administered to alcoholics in the form of a tablet which produces serious and extremely unpleasant reactions upon the consumption of even a small amount of alcohol. Reactions include bad headaches, breathlessness, nausea, thirst, palpitations, dizziness and fainting, and may last from thirty minutes to several hours.

4. Jacklin & Mischel (1973) observed that the stories in school textbooks show that the good events in men and boys lives were linked directly to the characters own actions; however, the good events in the lives of women and girls was related to the actions of others or as the indirect consequence of passing events. This suggests that

the gender difference in "locus of control" is a function of cultural stereotypes of masculinity and femininity.

5. Erikson (1950, 1968) maintained that emotional development starts in the first few months of life: the infant first learns to "trust", in developing an awareness that the people in her environment are benign and trustworthy. Concomitant with the learning of trust of others, the infant learns that she herself is worthy of trust: she develops confidence in her "essential constancy" in the face of external changes. And this is proven in her control of her own organic urges. Should this trust and self-confidence not be learnt, then according to Erikson, the individual becomes progressively estranged from others. And in her withdrawal from society, learns to behave in ways that are at odds with other people, and even her self.

The child has usually learnt "autonomy" and "initiative" by about the age of five. Autonomy involves the

".. strik[ing] of a socially useful balance between cooperation with others and pure wilfulness, avoiding both oversubmissiveness and compulsive self-restraint" (Burtie 1979b, p.147).

However, loss of self-control, like parental over-control, engenders a sense of doubt and shame, which is expressed in childhood obsessiveness and/or lack of self-assertion or overt rebellion in adolescence. "Initiative" enables the child to set goals and have ambitions. As initiative is learnt "achievement" becomes an objective in life. But failure to learn initiative entails a

".. lifetime of uncertainty about the validity of her actions and [the] develop[ment of] feelings of guilt about undertakings and decisions" (Burtie 1979b, p.147).

During her first year at school, the child learns "industry". In becoming more aware of the culture in which she lives, she begins to develop roles for herself within that environment. Her developing self discipline is seen in her working

towards "task-oriented goals". However, should the individual fail to learn industry, she will tend to feel inferior and be unable to cope.

Adolescence involves the consolidation of the skills learnt during childhood. Erikson holds that as the individual searches for people and causes that will provide her with a sense of identification, her value systems become distinct and independent from those of her family. Should the individual fail to allow herself some "extra-familial ideological affiliation" during adolescence, then she is likely to experience "identity confusion" - the lack of a common core of personality characteristics around which all roles and activities gravitate.

With adulthood, the individual learns firstly "intimacy". This skill or quality requires that the individual has a sufficient sense of her own identity to enable her to be sensitive to and to validate the identity of another. The achievement of intimacy is expressed in the making of commitments to

".. concrete affiliations and partnerships and to develop the ethical strength to abide by such commitments" (Erikson, quoted in Burtle 1979b).

Failure to learn intimacy entails the tendency of the individual to "repudiate" and "isolate" herself from others.

Finally, the skill of intimacy is enlarged by the learning of "generativity", namely the

".. conscious need to guide and nurture others, especially the young" (Burtle 1979b, p.148).

Failure to learn generativity is expressed in an "obsessional need for pseudo-intimacy", in the acquisition of superficial and tangential relationships which eventually leads to a sense of personal stagnation, boredom, emotional sterility and egocentricity:

".. individuals [will then] tend to indulge themselves as if they were their own or another's one and only child; and, where

conditions favour it, early invalidism, physical or psychological, becomes the vehicle of self-concern" (Erikson quoted in Burtle 1979b).

6. It is from this point that a post-structuralist analysis of women's drunkenness may develop.

7. However, from a more materialist perspective, such a belief may be regarded as entirely sensible within a society which demands women's abstinence and thus their economic and emotional dependence upon men (chapters 1 and 5).

8. Again, however, from a more materialist perspective, women can be seen to be blamed and held guilty for not conforming to type. This is particularly acute when women are inabstinentlly inaccessible/unamenable to men (chapters 1 and 5).

9. My discussion in chapter 5, and the results of my conversations with drunken women shows that although alcohol may provide such transient magical transformation to men, the symbolic means of such temporary escape are not available to women.

Chapter 4

1. Ferrence (1980) points out that there is some evidence that this trend may not continue: some surveys of young people indicate that the youngest cohorts were drinking less than previous cohorts at that age. It could be extrapolated from this data that there will be an increasing divergence in alcohol consumption among the future adult drinking.

2. This review was done covertly, and was never intended to become 'public property', and so remains unpublished in this country; it was, however, subsequently published in Sweden in 1982.

3. And this despite the fact that coroners are reluctant to certify death as being due to alcoholism or alcoholic psychosis in general, and in women in particular (Shaw 1980).

4. Breeze (1985) noted that

"Recently experts in the alcohol field have recommended upper limits for women of 6 units a day and 40mg or 4-5 units a day on a regular basis, that is 28-35 units a week" (Breeze 1985, p.2).

However, she also notes that this limit itself could not be justified by "hard evidence" of dramatic symptoms when marginally exceeded.

5. Wernicke-Korsakoff Syndrome occurs in individual who are alert but who exhibit memory loss of both recent and past events (retrograde and anterograde amnesia) and sometimes ophthalmoplegia (paralysis of one or more of the muscles that move the eye).

The higher frequency of Wernicke-Korsakoff Syndrome among women than men is usually attributed to the greater frequency with which women alcoholics neglect their diet; malnutrition is also thought to be one of the factors in the causation of alcoholic dementia.

6. Research points to two key areas which may be significant in accounting for the sex difference in the morbidity and mortality of alcoholics. Firstly, despite the development of equal opportunities, women and men alcoholics are likely to experience differences in "lifestyle" that may account for their differences in morbidity and mortality: while both men and women are likely to neglect themselves, to eat poorly and to misuse other drugs, especially prescribed tranquillisers and sedatives, some researchers (Wilkinson 1980) has found that women alcoholics may be more physically neglected than men (see also chapter 5). And secondly, related to the "lifestyle" differences between women and men alcoholics, women are likely to experience a different exposure to alcohol than men: although they tend to drink less than men, women's physiology will intensify the damage from alcohol; women also tend to prefer wine and currently researchers are debating whether or not wine is more toxic, especially to the liver, than other alcoholic beverages (Wilkinson 1980). And although women generally develop problem drinking later in life than men, once they begin to drink heavily they are likely to develop "uncontrolled" drinking

patterns far more quickly than men. See also chapter 5.

Chapter 5

1. I use the term 'bio-cultural' dialectic to indicate the biological bases of the Durkheimian perspective.

2. Unlike Marx, who saw the forced division of labour as a key means of the capitalist social order.

3. Such as nineteenth century sanitary legislation, the 1911 National Insurance Act and the institution of the National Health Service in 1948.

4. While the principle of welfare intervention was firmly established by the mid twentieth century, the particular form of welfare provision

".. reflects the outcomes of struggles, alliances and compromises between social classes, women and men and particular professional groups." (Dorn 1983)

Women (at the providers as well as the recipients of welfare), in particular, played a significant part in the political struggle out of which the welfare state was established (Banks 1981, Mark-Lawson, Savage & Warde 1985, Middleton 1978, Vicinus 1985).

5. The "sick role" is characterised by four major characteristics: i. exemption from normal social responsibilities; ii. freedom from blame for being sick; iii. the expectation that the sick person will seek professional medical help since illness is undesirable or 'aversive' (chapter 3); and iv. that the sick person will comply with the prescription of a medic.

6. Norms make sense *only* within *specific* social frameworks (Smart & Smart 1978): the feminine norm of dependency, therefore, is specific to patriarchal society, rather than being a universal or essential characteristic of all women.

7. In terms of either conception, inabstinent women are defined in terms of their lack of *will*

(chapters 1 & 3), and as such, inhuman - denied the benefits of civilised society, such as paternalistic protection.

8. in terms of initial recognition of drinking problems and also in terms of the material facilities provided, such as creches, flexible open hours etc

9. Gramsci's (1971) concept of "hegemony" is important here: he saw 'rule' as established through a mixture of consensus (or consent) and coercion. The relation of consensus and coercion was not conceived as a balance, as if they were simply complimentary and additive; rather their relation is one of interdependence.

"In the political system, a .. structural (non-additive and non-transitive) relationship between ideology and repression, consent and coercion prevails. The normal conditions of ideological submission of the masses .. are themselves constituted by a silent, absent force which gives them their currency: the monopoly of legitimate violence by the State. Deprived of this, the system of cultural control would instantly be fragile, since the limits of possible actions against it would disappear. With it, it is immensely powerful - so powerful that it can, paradoxically, do 'without' it: in effect, violence may normally scarcely appear within the bounds of the system at all" (Anderson, 1967-8, p.43).

11. Several writers have pointed out that women's divorce from waged labour 'frees' them to engage totally in unpaid labour at home - feeding and caring for workers (and future workers). This functional role ensures the reproduction/ /maintenance of the human means of production without any (capital) cost (Barrett 1980). Hence women's functional abstinence from waged labour.

12. In addition to the separation of home and work and the ideology of women's place (the ideological distinction between the public and the private), the other dimensions of social control that women alone experience within western patriarchy concern

1. the reproductive cycle - the mystification of pregnancy, the control of

the medics and women's diminished knowledge of their own bodies;

ii. the double standard of morality, especially regarding sexuality;

iii. women's subordinate legal and social status - their lack of social status underpinned by women's anomalous position regarding legal and civil rights. Also the welfare state's conception of the woman at home which therefore perpetuates women's subordinate status and dependency on men.

See Smart & Smart 1978. The social control of women's (in)abstinence includes all of these areas.

12. See Smart (1976) on the functional equivalence of men's crime and women's madness

13. The efficacy of organic stereotypes of (drunken) women ensures that drunken women remain 'unlabelled' until their behaviour corresponds to the stereotype. As soon as they do 'fit' the stereotype, however, their drunkenness "telescopes" in terms of the amplification of their 'feminine' dependency, but also in terms of the physical harm that they encounter through such prolonged use and high consumption levels of alcohol. Their original 'non-labelling' rapidly becomes an indelible label (Lemert 1951, Becker 1967, Young 1971, Robinson 1976, 1977) to fulfill the promises of the Ledermann (chapter 4) vision of women's greater than exponential harm through their consumption of alcohol. All the extreme manifestations of alcoholism (chapter 2) that in 'normal' (male) cases take years to develop, "telescope" into a short period following the first incidence of labelling.

14. "The 'problem' here is not that these women have been misguided by men, but that *they accept no male guidance at all.*" (Perry 1979, p3, my emphasis)

Chapter 6

1. Interestingly, Comte tried to develop positivism into a sort of religion: he established "Positive Societies" in several countries in which the worship of 'humanity' replaced the worship of God.

2. Popper's "hypothetico-deductive" methodology can be seen as intrinsically related to the simultaneous development of (British) government through a social democratic consensus: both were premised upon an assumption of a socially bounded network of shared meanings. In Poppers case, such a network of meanings was necessary for the identification and measurement of 'natural' phenomena; in the case of the social democratic consensus, shared meanings provided the basis for the institution of the Welfare State through the consensual identification of ('natural'?) social 'problems' (Douglas 1971)

3. See my discussion in chapter 3 regarding "gradients of reinforcement"; and also chapter 5 concerning the development of approaches to the understanding of drunkenness in terms of the interaction of operant with cultural factors.

4. See Kuhn on the argument that scientific change is more about the replacement of one paradigm than another.

5. Note the echoes of the nineteenth century separation of the public from the private worlds: the public identified with the social, the private identified with the natural. The two distinct worlds, however, were articulated through 'the natural' insofar as men's consumption of women was in physical/biological terms, such as sex, drink and food. See my later discussion of the necessary bifurcation of the sociological researcher from his physical/biological location in order to produce 'sociology' (Smith 1977).

6. I defined Glasgow through the 041- telephone code prefix

Chapter 7

1. The numbers in brackets refer to the actual number of workers/women who stated the view in question.

Chapter 8

1. The numbers in brackets refer to the actual number of workers/women who stated the view in question.

APPENDIX 1: POSTAL QUESTIONNAIRE

1. What is the name of your organisation/service?

Name:.....

Address:.....

.....

.....

Phone Number:.....

Contact Name/s:.....

Governing/funding body:.....

.....

2. Do you provide a service for people

a. specifically with alcohol problems? Y/N

b. with problems related to alcohol use? Y/N

c. with general problems including addictions? Y/N

**3. What is the main type of service that you
provide (eg counselling, residential, social)?**

What other type/s of service do you provide?

**4. Do you provide any services specifically for
women with alcohol problems or related
difficulties? Y/N**

If not, do you plan to introduce any such
service? Y/N

5. Can women clients/patients see a woman staff-member? Y/N

7. Roughly, what is the percentage of women staff in your organisation?

1% - 10%
11% - 20%
21% - 30%
31% - 40%
41% - 50%
51% - 60%
61% - 70%
71% - 80%
81% - 90%
91% - 100%

8. Does your organisation provide any in-service training in alcohol problems or related difficulties? Y/N

9. Does your organisation ever refer clients/patients to other organisations? Y/N

If so, which?

10. Does your organisation ever receive referrals from other organisations or individuals (eg patients/clients themselves, intimates of patients/clients, GPs, Social Workers, Police)? Y/N

If so, which?

**11. Do you see a need for facilities for women
alcohol-users in Glasgow which don't exist?**
Y/N

If so, what?

**12. Do you know of any other services for women
alcohol-users in Glasgow which I should
contact? If so please note the details below.**

COVERING LETTER ATTACHED TO POSTAL QUESTIONNAIRE



UNIVERSITY OF GLASGOW

Department of Social Administration and Social Work

53-57 SOUTHPARK AVENUE, GLASGOW G12 8LF

041-339 8855 ext

Acting Head of Department: Miss Jill D. Ford.

Dear

I am a post-graduate student engaged in research on women and alcohol use in Glasgow. As part of my project, I am concerned to ascertain the level of service provision for women alcohol-users in Glasgow.

I would be much obliged if you could complete the attached questionnaire and return it to me as soon as possible.

Yours sincerely

Sheila M.C.Inglis

APPENDIX 2: DIRECTORY OF AGENCIES SURVEYED

<u>TITLE, ADDRESS AND TEL NO</u>	<u>MAIN FUNDING/ GOVERNING BODY</u>	<u>MAIN SERVICES PROVIDED</u>
ADDICTION INFORMATION CENTRE West 1 Social Work Department 234 Kinfrauns Drive Drumchapel Glasgow G15 7AH 041-944-4242	SRC/UA*	Individual counselling, group work, drop-in and social
ALANON Room 13 136 Ingram Street Glasgow 041-552-2828	Voluntary	Group therapy, information
ALBAN HOUSE 3 Cavendish Street Glasgow 041-429-7744	Voluntary/UA*	Dry social centre, individual counselling and group work
ALCOHOLICS ANONYMOUS Scottish Service Office 50 Wellington Street Glasgow 041-221-9027	Voluntary	Individual counselling and group work
ALCOHOL/DRUG REHABILITATION CENTRE 101 Denmark Street Possilpark Glasgow G22 041-336-5311	GGHB*	Out-patient facilities, individual counselling, group therapy, relaxation and exercise

ALCOHOL INFORMATION AND ADVICE CENTRE 1345 Gallowgate Parkhead Glasgow 041-554-2659	SRC/UA*	Individual counselling (including relatives), group work, social skills and activities, information and advice to other agencies
CASTLEMILK ALCOHOL ADVICE CENTRE 15 Dougrie Terrace Castlemilk glasgow 041-631-3329	SRC*	Individual counselling (including relatives) day centre, information
CASTLEMILK DRUG PROJECT 9-11 Ballantay Quadrant Castlemilk 041-634-0711	SRC SWD* SHHF*	Individual counselling, information, advice to other agencies, development of community resources
CLYDEBANK DISTRICT COUNCIL ON ALCOHOL Stirling house Mill Road Glasgow 041-952-0996	Voluntary	Advice and information by telephone, confidential visits, counselling, group work, alcohol clinic, residential
CHARING CROSS CLINIC 8 Woodside Crescent Glasgow G3 7UY 041-332-5463	CGHB	6 week recovery programme, including recreational provision for relatives, under 30s programme, counselling and group work
COMMUNITY ALCOHOL TEAM Community Services Centre St Marys School Queen Street Paisley PA1 2TU 041-889-1555	Collaborative	In-service training for professionals in alcohol related problems, consultation, advice and support to any individual professional, information resource centre

DRUMRY DROP IN CENTRE
The Lesser Hall
Kilbowie parish Church
Drumry Road
Clydebank
041-952-0225

SRC SMD* Social and recreational facilities,
confidential advisory and counselling
service

DUKE STREET HOSPITAL
Department of Psychiatry
Duke Street Hospital
253 Duke Street
Glasgow
041-556-5222/554-6267

GGHB* Psychiatric in-patient, out-patient and
day patient care

DYKEBAR HOSPITAL
Grahamston Road
Paisley PA2 7ED
041-884-5122

ACHB* In-patient, out-patient and day-patient
care, individual counselling and group
work

EASTERHOUSE COMMITTEE ON
DRUG ADDICTION
8-10 Arncliffe Road
Easterhouse
Glasgow G34
041-773-2001

collaborative Information, advice, recreational
facilities, counselling

GARTNAVAL ROYAL HOSPITAL
Alcohol Treatment Unit
1055 Great Western Road]Glasgow
041-334-6241

GGHB* In-patient and day-patient care

GLASGOW COUNCIL ON ALCOHOL
82 West Regent Street
Glasgow G2 2QF
041-333-9111

Voluntary Individual counselling (including
relatives)

GLANAFTON NURSING HOME 50 St Andrews Drive Glasgow G41 041-427-2087	Private	Residential nursing care
INDUSTRIAL ALCOHOLISM UNIT 82 West Regent Street Glasgow G2 2QF 041-332-7936	Voluntary	Company and employee counselling, educational and policy seminars
INGLEFIELD STREET HOSTEL 21 Inglefield Street Govanhill Glasgow G42 7AY 041-423-1287	GDC HMD*	Residential women-only care
JEAN MORRIS HOUSE 218 Bath Street Glasgow G2 041-332-1757	GDC HMD*	Residential women-only care
LEVERNDALE HOSPITAL Crookston Road Glasgow G53 041-882-6255	GGHB*	In-patient, out-patient and day-patient care
NORMAL STREET HOSTEL 93 Norman Street Glasgow G40 041-554-5219	GDC HMD*	Residential care
NORTH POLLOK ADDICTION CENTRE The Linthaugh Centre 20 Lindhaugh Road Pollok Glasgow 041-810-5200	SRC SWD*	Individual counselling (including relatives), group work including sport, recreation, education, assertiveness. Information and advice for individuals and community groups

THE PLACE St Matthews Rectory 200 Balmore Road possilpark Glasgow 041-336-8147	Voluntary	Counselling, detoxification
POSSIL DRUG PROJECT 101 Denmark Street Glasgow 041-336-3365	SHHD*	Counselling, advice and information, recreation, training
PRIESTHILL/NITSHILL ALCOHOL INFORMATION SERVICE Overtown Centre 17 Overtown Avenue Glasgow G53 041-880-7828	SRC SWD*	Information and advice, counselling, day centre
RAINBOW HOUSE 1 Belhaven terrace Glasgow G12 041-339-2691	CSBSC*	Residential accommodation, day programme, counselling, family groups
RENFREW DISTRICT COUNCIL ON ALCOHOL Community Services Centre Queen Street Paisley PA1 2TU 041-887-0880/889-1061	Voluntary	Individual counselling (including relatives), group work, dry social club, dry supported accommodation
SALVATION ARMY Hope House 14 Clyde Street Glasgow G1 5JH 041-552-0537	Voluntary	Residential care, social, counselling

SCOTTISH COUNCIL ON ALCOHOL Voluntary
147 Blythwood Street
Glasgow G2 4EN
041-333-9677

Training voluntary counsellors in local
Councils on Alcohol, training of primary
care workers, co-ordination of services,
liaison with other agencies

THE SIMON COMMUNITY Voluntary
133 Hill Street
Glasgow G3 6UB
041-332-3448

Residential accommodation

SOUTHERN GENERAL HOSPITAL GGHIB*
Alcohol Programme
Glasgow G51 4TF
041-445-2466

In-patient care, alcohol withdrawal day
programme

ST ENOCH CENTRE Voluntary/UA*
13 South Portland Street
Glasgow G5
041-429-4757

Day rehabilitation service, counselling,
advice

TALBOT ASSOCIATION
WOMENS CENTRE Voluntary/UA*
122 Hill Street
Glasgow
041-332-7717

Day and night centre for women, care and
and Alcohol Units, counselling, self-help

TOM ALLAN CENTRE CSBSR*
23 Elmbank Street
Glasgow G2 4PB
041-221-1535

Counselling

WESTERCRAIGS ALCOHOL PROBLEMS
RESOURCE CENTRE CSBSR*
21 Westlands Drive
Glasgow G14
041-959-1679

Dry residential care, social skills,
counselling, family therapy

WOODLEE HOSPITAL
Lenzie
Glasgow G66 3UG
041-776-2451

GGHB*

In-patient, out-patient and day-patient
care, counselling, social, liaison with
residential facilities

* Funding/Governing body abbreviations:

SRC	Strathclyde Regional Council
UA	Urban Aid
GGHB	Greater Glasgow Health Board
SWD	Social Work Department
ACHB	Argyll & Clyde Health Board
GDC	Glasgow District Council
HMD	Housing Management Department
SHHD	Scottish Home & Health Department
CSBSC	Church of Scotland Board of Social Responsibility

APPENDIX 3: SURVEY OF SERVICE FOR DRUNKEN WOMEN IN GLASGOW

Table 1a: Main type of service provided

Education	29
counselling	25
Hospital (in/out patient)	13
Residential	11
Social	10
Group therapy/work/meetings	7
Social Skills	2
Day Centre	2
Professional training	2
24hour answering service for relatives	1
Support, training and information for community groups	1
Problem Solving Networks	1
Individual programmes/medication	1

Table 1b: Other types of service provided

Information	7
Advise to other agencies	6
Counselling	5
Referral of clients	4
Meetings/group work	4
Social	2
Psychotherapy	2
Drug treatment	2
Food	1
Day Centre	1
Public Campaigns	1
Family Therapy	1
Detoxification	1
Drop-In	1

Table 2a: Provision of services specific to women

yes	
16	
no	
22	
TOTAL RESPONDENTS	
38	
	if no do you have plans for
	services specific to women
4	yes
	no
15	
	no reply
3	

Table 2b: Availability of women staff for women clients/patients

yes	35
no	0
don't know	1
no reply	2
TOTAL RESPONDENTS	38

Table 2c: Percentage of women staff in agency

1% - 10%	0
11% - 20%	2
21% - 30%	3
31% - 40%	2
41% - 50%	10
51% - 60%	2
61% - 70%	7
71% - 80%	2
81% - 90%	2
91% - 100%	2
No reply	6
TOTAL RESPONDENTS	38

Table 2d: Perceived need for services specific to women

yes	18
no	7
don't know	13
TOTAL RESPONDENTS	38

Table 2e: Nature of specific women's services needed

Women only groups	4
Residential	3
Refuges for women & children	3
Programmes with creches	2
Dry Houses	1
Rehabilitation accommodation	1
Women's Centres for users	1
Women's day centres	1
Women-gearred groups	1
Self-help groups	1
Drinkwatchers	1
Crisis phone line	1
Specific women's educational forum	1
More knowledge	1
Literature	1
health promotion	1

Table 3a: Agencies from which clients/patients are received

Social Work Department	30
GP	27
Clients/patients themselves	21
Intimates of client/patient	15
Hospitals	12
Courts	10
Police	9
Hospital Programmes	7
Ministers/priests	6
Councils on Alcohol	5
Alcoholics Anonymous	4
Industrial Alcohol Unit	3
Employers	3
Citizens Advice Bureaux	2
SACRO *	2
Teachers/schools	2
Talbot Centre	2
Alateen	1
Homeless persons hostels	1
Rehabilitation hostels	1
Women's Aid	1
Castlemilk Law Centre	1
Trade Unions	1
Samaritans	1
Marriage Guidance	1
Community Psychiatric Nurses	1
Home Helps	1

* Scottish Association for the Care and
Resettlement of Offenders

Table 3b: Agencies to which clients/patients are
referred

Residential rehabilitation	17
Hospital Programmes	16
Councils on Alcohol	13
Alcoholics Anonymous	12
Social Work Department	8
GPs	7
Hospitals generally	6
Alcohol/drug agencies	6
Homeless persons hostels	5
Women's Aid	4
Marriage Guidance	3
Rape Crisis Centre	3
Alanon	3
Castlemilk Law Centre	1
Family Support Group	1
Alateen	1
Post Alateen	1
Samaritans	1
Women's Centres	1
Citizens Advice Bureaux	1
RSPCC	1
Charing Cross Clinic	1

Table 4: Provision of in-service training for
staff

yes	24
no	13
don't know	1
TOTAL RESPONDENTS	38

APPENDIX 4: DISCUSSION SCHEDULES

1. AGENCY WORKER'S SEMI-STRUCTURED INTERVIEW SCHEDULES

Date:

ORGANISATION:

1. Do you classify your (women) clients/patients according to any specific criteria?

2. Do you think that women clients/patients have any specific problems which are different from those of men?

3. Do you think that women clients/patients have any special needs which are different from those of men?

4. Why do you think that women have drinking problems?

5. Why do you think that men have drinking problems?

6. Do you think that women professional treat women alcoholics/problem drinkers in a way which is different from the ways in which male professionals treat them?

7. Do you think that organisations should have workers who have had some specialised training to help people with alcohol problems and related difficulties?

8. Have you had any specialised training?

9. Does your organisation have any particular approach to treating your clients/patients?

10. Do you think that there is any difference between an "alcoholic" and a "problem drinker"?

11. Do you, yourself drink alcohol?

12. Have you ever had any of the problems which your clients/patients have had?

13. Do you find it easy/difficult to become "involved" with your clients/patients?

2. SEMI-STRUCTURED GROUP DISCUSSION WITH WOMEN

Date:

ORGANISATION:

1. SOCIAL ATTITUDES TO WOMEN DRINKING

**Pubs
Parties
Men's attitudes
Drunkenness
Drinking Alone
Media
What do women drink?
Where do women drink?**

2. WHY DO WOMEN DRINK?

3. WHY DO WOMEN DEVELOP DRINK PROBLEMS?

4. DO YOU THINK THAT THE TREATMENT OF WOMEN WITH DRINK PROBLEMS IS OK?

3. WOMEN'S SEMI-STRUCTURED INTERVIEW SCHEDULE

1. General Background (Age, Family etc)

2. Personal drinking history

3. Social attitudes to women drinking

4. Woman's explanation of her drinking problem

5. Discussion of treatment

APPENDIX 5: LOCATION OF DISCUSSIONS

Table 1: Nature of Workers Interviewed:

AGENCY TITLE	AGENCY TYPE	SEX OF INTERVIEWEE
Addiction Information Centre, Drumchapel	Social Service Advisory & Counselling	Female
Alcoholics Anonymous	Voluntary Self-Help	Male
Alcohol Information and Advice Centre, Parkhead	Social Service Advisory & Counselling	Female
Castlemilk Alcohol Advice Centre	Social Service Advisory & Counselling	Male
Clydebank District Council on Alcohol	Voluntary Advisory & Counselling Residential	Female
Charing Cross Clinic	Health Service NHS Out-patient	Male
Community Alcohol Team	Social Service Worker support & training Services Co-ordination	Male
Gartnavel Royal Hospital, ATU	Health Service NHS In & Out-patient	Female
Glasgow Council on Alcohol	Voluntary Advisory & Counselling	Male
Industrial Alcohol Unit	Voluntary Advisory & Counselling	Male

North Pollok Addiction Centre	Social Services Advisory & Counselling	Female
Renfrew District Council on Alcohol	Voluntary Advisory & Counselling Residential	Male
Scottish Council on Alcohol	Voluntary Voluntary worker support & training Services co-ordination	Female
Simon Community	Voluntary Residential	Female
Southern General Hospital, Alcohol Programme	Health Service NHS In & Out-patient	Female
St. Enoch Centre	Voluntary Advisory & Counselling	Male
Talbot Association, Womens Centre	Voluntary Advisory & Counselling Residential	Male & Female
Tom Allan Centre	Church Advisory & Counselling	Male
Westercraigs Alcohol Problems Resource Centre	Church Residential	Male
Woodilee Hospital	Health Service NHS In & Out-patient	Male

Table 2: Advisory & Counselling Agencies Interviewed

Agency Title	Non/Statutory	Interviewee Sex
Addiction Information Centre, Drumchapel	Statuary*	Female
Alcohol Information & Advice Centre, Parkhead	Statuary*	Female
Castlemilk Drug Project	Statuary	Male
Clydebank District Council on Alcohol	Non-Statuary	Female
Glasgow Council on Alcohol	Non-Statuary	Male
Industrial Alcohol Unit	Non-Statuary	Male
North Pollok Addiction Centre	Statuary	Female
Renfrew District Council on Alcohol	Non-Statuary	Male
St Enoch Centre	Non-Statuary	Male
Talbot Association	Non-Statuary	Male & Female
Tom Allan Centre	Non-Statuary	Male

* Also reliant upon Urban Aid funding

Table 3: Residential Agencies Interviewed

Agency Title	Non/Statutory	Interviewee Sex
Clydebank District Council on Alcohol	Non-Statuary	Female
Renfrew District Council on Alcohol	Non-Statuary	Male
Simon Community	Non-Statuary	Female
Talbot Association	Non-Statuary	Male & Female
Westercraigs Alcohol Problems Resource Centre	Non-Statuary	Male

Table 4: National Health Service Agencies Interviewed

Agency Title	Sex of Interviewee
Charing Cross Clinic	Male
Gartnaval Royal Hospital, Alcohol Treatment Unit	Female
Southern General Hospital	Female
Woodilee Hospital	Male

Table 5: Worker Support & Training, and Services Co-Ordination Agencies Interviewed

Agency Title	Non/Statuary	Interviewee Sex
Community Alcohol Team	Statuary	Male
Scottish Council on Alcohol	Non-Statuary	Female

Table 6: Womens Group Discussion Location

Agency Title	Agency Type	Number of Participants	Names of Participants*
Alcohol Information & Advice Centre, Parkhead	Social Service Advisory & Counselling	5	Fiona, Louise, Rose, Eileen, Linda
Charing Cross Clinic	Health Service NHS Out-patient	8	Christine, Diane, Liz, Rona, Jane, Jackie, Ann, Kathy
Renfrew District Council on Alcohol	Voluntary Advisory & Counselling	4	Agnes, Joanne, Nicky, Lesley
Westercraigs Alcohol Problems Resource Centre	Church Residential	7	Mary, Susan, Kate, Jenny, Jean, Allison Pat.

* participants names refer to those used in the text: all names have been changed to protect the women's anonymity.

Table 7: Location of Individual Discussions with Women

Agency Title	Agency Type	Women's Names*
Alcohol Information & Advice Centre, Parkhead	Social Service Advisory & Counselling	Elsa, Frances
Charing Cross Clinic	Health Service NHS Out-Patient	Cath, Debbie
Gartnaval Royal Hospital	Health Service NHS In-patient	Gill, Helen, Isa
Westercraigs Alcohol Problems Resource Centre	Church Residential	Annie, Betty

* names refer to those used in the text: all names have been changed to protect the women's anonymity.

APPENDIX 6: TABULATED FINDINGS

Table 1: Workers perspectives on nature of women's drunkenness

TOTAL WORKERS	women	men	TOTAL
	9	11	20
Holding organic/functionalist view			
total	2	8	10
drunk women are more pathological	2	8	10
drunk women are more obdurate	-	2	2
women essential difference is protective	2	4	6
alcoholism is the ransom of emancipation			
total	2	5	7
stigma attached to women drinking reduced	1	2	3
alcohol industry now targets women	-	2	2
licensing changes	-	4	4
Holding radical/structuralist view			
total	8	2	10
symptomatic of women's greater social stress	5	1	6
women's confinement in the home	5	2	7
women's impoverishment	2	-	2
women's exclusion from traditional means of stress relief	5	2	7
sexual violence	3	5	8
social welfare intervention (labelling, loss of children)	3	1	4

Table 2a: Women's perspectives on the nature of their drunkenness (Group Discussions)

TOTAL WOMEN	A	B	C	D	TOTAL
	7	5	8	4	24
Women are not emancipated or liberated					
total	7	5	4	2	18
drink to cope with multiple roles	3	-	-	-	3
drink to cope generally	2	3	-	-	5
alcohol is more effective than prescribed drugs	4	4	1	-	9
drink to cope with general illness	1	-	-	-	1
drink to cope with male violence	-	-	1	-	1
drink to cope with feelings of rejection/helplessness	-	5	-	-	5
drink in the search for 'time-out'/pleasure					
total	3	5	2	1	11
solitary	3	2	2	1	8
social	-	5	-	-	5
Enforced abstinence					
total	7	5	4	4	20
by husband	1	-	1	-	2
particularly prohibition of social contact	-	-	3	-	3
marriage	4	3	1	-	8
loneliness	4	5	-	4	13
awareness of double standard of drinking/drunkenness	2	-	-	-	2
so hide drinking	-	1	-	1	2
so experience loneliness	3	5	-	-	8
Liberalisation of alcohol					
reduces double standard	2	2	4	1	9
reduced stigma of women drinking	1	2	-	1	4
Awareness of risk of sexual violence through public drunkenness					
total	5	5	3	3	16
because drunken/inabstinent women are not interested in men	-	1	-	-	1
Group A: Westercraigs; Group B: Parkhead; Group C: Charing Cross;					
Group D: Renfrew Council on Alcohol					

Table 2b: Women's perspectives on the nature of their drunkenness (Individual Discussions)

	A	B	C	D	E	F	G	H	I	TOTAL
Women are not liberated										
- total	Y	Y	Y	Y	Y	Y	Y	Y	Y	9
- drink to cope with multiple roles	-	-	-	-	-	-	Y	-	-	1
- drink to cope generally	-	-	Y	Y	-	Y	Y	Y	Y	6
- alcohol better than prescribed drugs	-	-	-	-	-	-	-	Y	-	1
- drink to cope with general illness	-	Y	-	-	-	-	-	-	-	1
- drink to cope with male violence	Y	Y	Y	Y	-	Y	-	-	-	5
- drink to cope with feeling helpless	-	-	Y	Y	-	Y	-	Y	-	4
- drink as 'time-out'/pleasure	-	-	Y	Y	-	Y	-	Y	-	4
total	-	-	Y	Y	Y	Y	-	Y	Y	6
solitary	-	-	Y	Y	-	-	-	Y	Y	4
social	-	-	-	-	Y	Y	-	-	-	2
Enforced abstinence										
- total	Y	Y	Y	-	Y	-	Y	Y	Y	7
- by husband	Y	Y	Y	-	Y	-	-	Y	Y	6
- especially stopping social contact	-	-	Y	-	-	-	-	-	-	1
- marriage	-	Y	Y	-	-	-	-	Y	Y	4
- loneliness	Y	-	Y	-	-	-	Y	-	Y	4
- aware of double standard of drinking	Y	-	-	-	-	-	-	-	-	1
- so hide drinking	-	-	-	-	-	-	-	Y	-	1
- so experience loneliness	-	Y	-	-	-	-	-	Y	Y	3
Liberalisation of alcohol										
- reduces stigma of women drinking	-	-	-	-	-	-	Y	-	-	1
Aware of risk of sexual violence through public drunkenness										
- total	Y	Y	Y	-	-	Y	Y	Y	-	6
- because drunken/inabstinent women are not interested in men	Y	-	Y	-	-	-	Y	-	-	4

Westercraigs: A, B; Charling Cross Clinic: C, D; Parkhead: E, F, Gartnavel: G, H, I.

Table 2c: Women's perspectives on the nature of their drunkenness (Group and Individual Discussions)

	Group	Individual	TOTAL
TOTAL WOMEN	24	9	33
Women are not emancipated or liberated			
total	18	9	27
drink to cope with multiple roles	3	1	4
drink to cope generally	5	6	11
alcohol is more effective than prescribed drugs	9	1	10
drink to cope with general illness	1	1	2
drink to cope with male violence	5	5	10
drink to cope with feelings of rejection/helplessness	5	4	9
drink in the search for 'time-out'/pleasure			
total	11	6	17
solitary	8	4	12
social	5	2	7
Enforced abstinence			
total	20	7	27
by husband	2	6	8
particularly prohibition of social contact	3	1	4
marriage	8	4	12
loneliness	13	4	17
awareness of double standard of drinking/drunkenness	2	1	3
so hide drinking	2	1	3
so experience loneliness	8	3	11
Liberalisation of alcohol reduces double standard	9	-	9
reduced stigma of women drinking	4	1	5
Aware of risk of sexual violence through public drunkenness	16	6	22
total			
since drunken/inabstinent women not interested in men	1	4	5

Table 3: Workers perspectives on treatment

TOTAL WORKERS	women		men		total
	9	11	11	20	
Abstinence as primary goal	1	4		5	
Rejection of disease concept					
total	7	7		14	
as 'old fashioned'	1	1		2	
drinking is response rather than illness	4	4		8	
Disease concept leads to stigma/telescoping	3	4		7	
Disease concept leads to labelling	2	2		2	
Treatment must deal with factors other than alcohol	9	7		16	
feminine rehabilitation	1	1		2	
relating to 'normal' men after experience of violence	-	3		3	
women prefer men workers/mixed groups	-	5		5	
women prefer women workers/women only groups	8	4		12	
women need women only facilities	6	3		10	
Need for women only treatment					
total	8	5		13	
due to essential sex differences	1	5		6	
due to ideological gender differences	3	7		10	
alcohol problems are gender neutral	4	6		10	
training facilitates objective/client centred approach	4	6		10	
focus on individual special needs	5	2		7	
due to social structural differences	5	-		5	
common women's structural position	5	2		7	
- enforced abstinence	4	2		6	
- domestic/childcare responsibilities	5	2		7	
Stigma attached to inabstinent women inhibits sober inabstinence	4	2		6	
Women have problems in maintaining self worth after treatment	5	2		7	

Table 4a: Women's perspectives on treatment (Group discussions)

TOTAL WOMEN	A	B	C	D	TOTAL
	7	5	8	4	24
Coerced into treatment					
total	2	5	3	-	10
in order to maintain custody of children through police intervention	2	4	2	-	8
Prefer hospital treatment	-	1	1	-	2
total	-	5	1	3	9
as a form of 'time out'	-	2	-	1	3
in order to regain health	-	5	1	2	8
Dislike hospital treatment					
total	7	-	3	-	10
false feeling of sickness/disease due to psychoanalytic treatment	1	-	3	-	4
Experience of Alcoholics Anonymous	7	-	-	-	7
total	6	-	1	4	11
like AA	2	-	-	2	4
dislike AA	4	-	1	2	7
Prefer a combination of group and individual therapy	1	-	2	1	4
Prefer group therapy					
total	-	-	4	4	8
but dislike big groups	-	-	1	2	3
but feel vulnerable with strangers in groups	2	-	2	-	4
but prefer women-only groups	2	-	3	1	6
Awareness of stigma of treatment					
total	7	4	2	-	13
feel that mixed treatment lessens stigma of treatment	2	2	2	-	6
Feel that treatment has been beneficial	7	4	1	2	14
Feel anxious about end of treatment					
total	2	3	1	-	6
about husbands acceptance of sober self	1	-	-	-	1
Experience of male hostility in treatment					
and inabstinent sobriety	-	-	1	-	1

Group A: Westercraigs; Group B: Parkhead; Group C: Charling Cross;

Group D: Renfrew Council on Alcohol

Table 4b: Women's perspectives on treatment (Individual discussions)

	A	B	C	D	E	F	G	H	I	TOTAL
Coerced into treatment										
total	Y	-	Y	Y	Y	Y	Y	Y	Y	8
to maintain custody of children	Y	-	Y	Y	Y	-	-	Y	-	5
through police intervention	-	-	-	Y	-	Y	-	-	-	2
through family demands	-	-	-	-	-	-	Y	-	Y	2
Prefer hospital treatment										
total	-	-	-	-	-	-	-	Y	Y	2
as a form of 'time out'	-	-	-	-	-	-	-	-	Y	1
in order to regain health	-	-	-	-	-	-	-	Y	-	1
Prefer Antabuse	-	-	-	Y	-	-	Y	-	-	2
Prefer health education	-	-	-	-	-	-	-	Y	-	1
Experience of Alcoholics Anonymous										
total	-	Y	-	Y	-	-	-	Y	Y	4
like AA	-	-	-	-	-	-	-	Y	-	1
dislike AA	-	-	Y	-	-	-	-	-	Y	2
Prefer group therapy	Y	Y	Y	Y	Y	Y	-	Y	Y	8
Awareness of stigma of treatment	-	-	-	-	-	-	-	Y	-	1
Feel that treatment has been beneficial	Y	Y	-	Y	Y	Y	-	Y	-	6
Feel anxious about end of treatment										
total	Y	Y	-	Y	Y	-	-	Y	Y	6
re means acceptance of sober self	Y	-	Y	Y	-	-	-	-	Y	4
Experience of male hostility in treatment										
and inabstinent sobriety	-	-	Y	Y	-	-	-	-	-	2

Y indicates 'yes'

Westercraigs: A, B; Charing Cross Clinic: C, D; Parkhead: E, F, Gartnaval: G, H, I.

Table 4c: Women's perspectives on treatment (Group and Individual discussions)

TOTAL WOMEN		Group	Individual	Total
		24	9	33
Coerced into treatment				
total		10	8	18
in order to maintain custody of children through police intervention		8	5	13
Prefer hospital treatment		2	2	4
total		9	2	11
as a form of 'time out' in order to regain health		3	1	4
Dislike hospital treatment		8	1	9
total		10	-	10
false feeling of sickness/disease due to psychoanalytic treatment		4	-	4
Prefer Antabuse		7	-	7
Prefer Health Education		-	2	2
Experience of Alcoholics Anonymous		-	1	1
total		11	4	15
like AA		4	1	5
dislike AA		7	2	9
Prefer a combination of group and individual therapy		4	-	4
Prefer group therapy				
total		8	8	16
but dislike big groups		4	-	4
but feel vulnerable with strangers in groups		6	-	6
but prefer women-only groups		13	-	13
Awareness of stigma of treatment				
total		13	1	14
mixed treatment lessens stigma of treatment		6	-	6
Feel that treatment has been beneficial		14	6	20
Feel anxious about end of treatment				
total		6	6	12
about husbands acceptance of sober self		1	4	5
Experience of male hostility in treatment and inabstinent sobriety		1	2	3

REFERENCES

- Alcohol Concern (1987): *The Drinking Revolution: Building a Campaign for Safer Drinking*, Alcohol Concern, London
- Alcohol Interventions Training Unit and Addiction Research Unit (1986): *Womens Problems with Alcohol and Other Drugs: Improving our Response*, Conference Papers, London
- Alcoholics Anonymous (1963): 'The Bill W. - Carl Jung Letters', *Grapevine* (January) 26-31
- Alcoholics Anonymous (1976): *Alcoholic Anonymous*, AA World Services, New York
- Allan, C. (1985): 'Do women with alcohol problems require seperate services?', paper presented to Edinburgh District Council on Alcohol Women and Alcohol Conference, 27.11.85
- Allan, C. (1987): 'Seeking help for drinking problems from a community based agency. patterns of compliance among men and women', *British Journal of Addicition*, 82, 1143-1147
- Anderson, P. (1967-8): 'The Antinomies of Antonio Gramsci', *New Left Review*, 100, 5-80
- Annis, H.M. & Liban, C.C. (1980): 'Alcoholism in women: treatment modalities and outcomes' in O.J. Kalant, (ed): *Alcohol and Drug Problems in Women: Research Advances in Alcohol and Drug Problems*, Vol.5, Plenum, New York
- Armor, D. Polich, J. & Stambul, H. (1978): *Alcoholism and Treatment*, The Rand Corporation, Santa Monica, California
- Auld, J., Dorn, N., South, N. (1986): 'Irregular work, irregular pleasures: heroin in the 1980s', in R. Matthews & J. Young (eds): *Confronting Crime*, Sage, London
- Avon Council on Alcoholism (1982): *A Survey of Gateways to Treatment for Women in Avon*, Avon Council on Alcoholism, Bristol
- Bacci, C.L. (1990): *Same Difference: Feminism and Sexual Difference*, Unwin Hyman, London

- Bacon, M. (1976): Alcohol use in tribal societies', in B. Kissin & H. Beigleiter (eds): *The Biology of Alcoholism Vol 4: Social Aspects of Alcoholism*, Plenum, New York
- Badiet, P. (1975): 'Women and legal drugs: a review', in A. MacLennan (ed): *Women: Their Use of Alcohol and Other Legal Drugs: A Provincial Consultation*, Addiction Research Foundation of Ontario, Toronto, Canada
- Bailey, P. (1985): 'Do women with alcohol problems require separate services?', paper presented to Edinburgh District Council on Alcohol Women and Alcohol Conference, 27.11.85
- Baker Miller, J. (ed)(1974): *Psychoanalysis and Women*, Penguin, London
- Baldamus, W. (1977): 'The category of pragmatic knowledge', in M. Bulmer (ed): *Sociological Research Methods*, Macmillan, London
- Bales, R.F. (1946): 'Cultural differences in rates of alcoholism', *Quarterly Journal of Studies on Alcohol*, 6, 480-499
- Bandura, A. (1969): *Principles of Behaviour Modification*, Holt, Rinehart & Winston, New York
- Banks, O. (1981): *Faces of Feminism: A Study of Feminism as a Social Movement*, Martin Robertson, Oxford
- Barker, D. and Allen, S. (eds) (1976): *Dependence and Exploitation in Work and Marriage*, Longman, London
- Bardwick, J. (1971): *The Psychology of Women*, Harper and Row, New York
- Barrett, M. (1980): *Womens Oppression Today: Problems in Marxist Feminist Analysis*, Verso, London
- Beccaria, C (1804): *Essay on Crimes and Punishments*

- Becker, H.S. (1967): 'History, culture and subjective experience', *The Journal of Health and Social Behaviour*, 8, 163-76
- Belfer, M.L. & Shader, R.I. (1976): 'Premenstrual factors as determinants of alcoholism in women' in M.Greenblatt & M.A.Schukit (eds): *Alcoholism Problems in Women and Children*, Grune & Stratton, New York
- Belfer, M.L., Shader, R.I., Carroll, M. & Hermatz, J.S. (1971): 'Alcoholism in women', *Archives of General Psychiatry*, 25, 540-544
- Benjamin, W. (1973): *Understanding Brecht* (trans. A.Bostock)
- Bentham, J (1798): *Introduction to the Principles of Morals and Legislation*
- Berger, B. (1963): 'The sociology of leisure', in E.O. Smigel (ed): *Work and Leisure*, College and University Press, New Haven, Conn.
- Bernard, J. (1973): 'My four revolutions', in J.Huber (ed): *Changing Women in a Changing Society*, University of Chicago Press, Chicago
- Bierstedt, R. (1966): 'Sociology and General Education', in C.H.Page (ed): *Sociology and Contemporary Education*, Random House, New York
- Blane, H.T. (1968): *The Personality of the Alcoholic*, Harper & Row, New York
- Block, J. & Hahn, N. (1971): *Lives through Time*, Bancroft Books, Berkeley
- Boothroyd, W.E. (1980): 'Nature and development of alcoholism in women' in O.J.Kalant (ed): *Alcohol and Drug Problems in Women: Research Advances in Alcohol and Drug Problems, Vol.5*, Plenum, New York
- Bowles, G. & Duelli Klein, R. (eds)(1983): *Theories of Women's Studies*, Routledge and Kegan Paul, London

- Brake, M. (1980): *The Sociology of Youth Culture and Youth Subcultures*, Routledge and Kegan Paul, London
- Brannen, D. & Collard, J. (1982): *Marriages in Trouble: The Process of Seeking Help*, Tavistock, London
- Bravermann, H. (1974): *Labour and Monopoly Capital: The Degradation of Work in the Twentieth Century*, Monthly Review Press, New York
- Brecht, B. (1975): 'Theatre for Pleasure' in D.Craig (ed): *Marxists on Literature*, Penguin, London
- Breeze, E. (1985): *Women and Drinking: An Enquiry Carried Out on Behalf of the Department of Health and Social Security*, HMSO, London
- Brown, G. & Harris, T. (1978): *The Social Origins of Depression*, Tavistock, London
- Brown, R. (1980): The role, selection and training of voluntary counsellors in alcoholism', in J.Madden, B.Walker & W.Keynon (eds): *Aspects of Alcohol Problems*, Pitman Medical, Tunbridge Wells
- Broverman, I.K., Broverman, D.M., Clarkson, E.E., Rosengrantz, P.S., & Vogel, S.R. (1970): 'Sex role stereotypes and clinical judgements of mental health', *Journal of Consulting and Clinical psychology*, 34, 1.
- Bulmer, M. (ed) (1977): *Sociological Research Methods*, Macmillian, London
- Burtle, V. (ed) (1979): *Women Who Drink: Alcoholic Experience and Psychotherapy*, Charles C. Thomas, Illinois
- Burns, M. (1979a): 'Women and alcohol: an overview', in V.Burtle, (ed): *Women Who Drink: Alcoholic Experience and Psychotherapy*, Charles C. Thomas, Illinois

- Burtie, V. (1979b): 'Developmental/learning correlates of alcoholism in women' in V.Burtie (ed): *Women Who Drink: Alcoholic Experience and Psychotherapy*, Charles C. Thomas, Illinois
- Busfield, J (1986): *Managing madness: Changing Ideas and Practice*, Unwin Hyman, London
- Cahalan, D. (1970): *Problem Drinkers*, Jossey Bass Inc, San Francisco
- Camberwell Council on Alcohol (1980): *Women and Alcohol*, Tavistock, London
- Cappell, H. (1977): 'Behavioural analyses of alcoholism', in G. Edwards & M. Grant (eds): *Alcoholism: New Knowledge and New Responses*, Croom Helm, London
- Carlson, R. (1971): 'Sex differences in ego functioning: exploratory studies of agency and communion', *Journal of Consulting and Clinical Psychology*, 37, (2), 267-277
- Carlson, R. (1972): 'Understanding women: implications for personality theory and research', *American Journal of Sociology*, 78, 4
- Cartwright, A., Shaw, S., & Spratley, T. (1975): *Designing a Comprehensive Community Response to Problems of Alcohol Abuse*, Report to the DHSS, Maudsley Alcohol Pilot Project, London
- Central Policy Review Staff (1979): *Alcohol Policies in the UK*, Sociologiska Institutionen, Stockholm Universitet (presented to UK government 1979)
- Chadwick, E. (1842): *Report on the Sanitary Conditions of the Labouring Population of Great Britain* (edited and with an introduction by M.W.Flinn 1965)
- Chesler, P. (1974): *Women and Madness*, Allen Lane, London
- Cicourel, A.V. (1964): *Method and Measurement in Sociology*, The Free Press, New York

- Clarke, W.B. & Cahalan, D. (1977): 'Changes in problem drinking over a four year span' in E.M.Pattison, M.B.Sobell & L.C.Sobell (eds): *Emerging Concepts of Alcohol Dependence*, Springer Publishing Co.
- Colfax, J. & Roach, J. (eds)(1971): *Radical Sociology*, Basic Books, London
- Comte, A. (1838): *The Positive Philosophy of Auguste Comte*, Bell, London (1896)
- Connell, M., Davies, T., McIntosh, S., & Root, M. (1981): 'Romance and sexuality: between the devil and the deep blue sea?', in A.McRobbie & T.McCabe (eds): *Feminism for Girls: An Adventure Story*, Routledge and Kegan Paul, London
- Cook, J. & Lewington, M (1979) (eds): *Images of Alcoholism*, Tavistock, London
- Cooperstock, R. (1972): 'From a study conducted among a sample of General Practitioners in Scotland', unpublished manuscript
- Cooperstock, R. (ed)(1974): *Social Aspects of the Medical Use of Psychotropic Drugs*, ARF Books, Toronto
- Cooperstock, R. (1975): 'Women and Psychotropic drugs', in A.MacLennan (ed): *Women: Their Use of Alcohol and Other Legal Drugs: A Provincial Consultation*, Addiction Research Foundation of Ontario, Tronto, Canada
- Cooperstock, R. (1977): 'Women and psychotropic drug use', in J.Dowsling & A.MacLennan (eds): *The Chemically Dependent Woman: Recognition, Referral, Rehabilitation*, Proceedings of a Conference Sponsored by the Donwood Foundation, Addiction Research Foundation, Toronto
- Corrigan, E.M. (1980): *Alcoholic Women in Treatment*, Oxford University Press, Oxford

- Corrigan, E. (1986): 'Identifying women's needs in treatment programmes', in Alcohol Interventions Training Unit and Addiction Research Unit: *Womens Problems with Alcohol and Other Drugs: Improving our Response*, Conference, London
- Coyner, S. (1983): 'Women's studies as an academic discipline: why and how to do it', in G.Bowles & R.Duelli Klein (eds): *Theories of Women's Studies*, Routledge and Kegan Paul, London
- Craig, D. (ed)(1975): *Marxists on Literature*, Penguin, London
- Crawford, S. & Ryder, D. (1986): 'A study of sex differences in cognitive impairment in alcoholics using traditional and computer-based tests', *Drug and Alcohol Dependence*, 18, 369-375
- Cressey, D. (1971): 'Role theory, differential association and compulsive crimes', in A.M.Rose (ed): *Human Behaviour and Social Processes*, Routledge and Kegan Paul, London
- Curlee, J. (1967): 'Alcoholic women: some considerations for further research', *Bulletin of the Menninger Clinic*, 31, 154-163
- Curlee, J. (1969): 'Alcoholism and the empty nest', *Bulletin of the Menninger Clinic*, 33, 165-171
- Dahl, T.S. & Snare, A. (1978): 'The coercion of privacy: a feminist perspective' in C.Smart and B.Smart (eds): *Women, Sexuality and Social Control*, Routledge and Kegan Paul, London
- Dalton, K. (1964): *The Premenstrual Syndrome*, Thomas, Springfield, Illinois
- Daly, M. (1973): *Beyond God the Father*, Beacon Press, Boston
- Darwin, C. (1871): *Descent of Man*, John Murray, London

- Davies, D.L. (1962): 'Normal drinking in recovered alcohol addicts', *Quarterly Journal of Studies on Alcohol*, 23, 94-104
- Davies, D. L. (1974): 'Is alcoholism really a disease', *Contemporary Drug Problems*, 3, 2, 197-212
- Davies, J. (1982): 'A psychological look at willpower and motivation', *Salud!*, 1, Alcohol Studies Centre, Paisley College
- De Lint, J & Schmidt, W. (1971): 'Consumption averages and alcoholism prevalence: a brief review of epidemiological investigations', *British Journal of Addiction*, 66 pp.97-107 OR 72 237-46
- Denzin, N. (ed)(1970): *Sociological Methods: A Sourcebook*, Butterworths, London
- Denzin, N. (1987): *The Alcoholic Self*, Sage
- Department of Health and Social Security (1973): *A Medical Memorandum on Alcoholism*, HMSO, London
- Department of Health and Social Security (1982): *Drinking Sensibly*, HMSO, London
- Dewes, P.B. (1972): 'Comment on the alcoholologist's addiction', *Quarterly Journal of Studies on Alcohol*, 33, 1045-1047
- d'Holbach (1770): *Systeme de la Nature*
- Dight, S.E. (1976): *Scottish Drinking Habits*, HMSO, London
- Doerner, K. (1981): *Madmen and the Bourgeoisie*, Blackwell
- Dorn, N. (1983): *Alcohol, Youth and the State*, Croom Helm, Kent
- Douglas, J. (1971): *American Social Order*, Free Press, New York

- Dowsling, J. & MacLennan, A. (eds) (1977): *The Chemically Dependent Woman: Recognition, Referral, Rehabilitation*, Proceedings of a Conference Sponsored by the Donwood Foundation, Addiction Research Foundation, Toronto
- Dowsling, J. (1977): 'The chemical trap: a physicians perspective', in J.Dowsling & A. MacLennan, (eds): *The Chemically Dependent Woman: Recognition, Referral, Rehabilitation*, Proceedings of a Conference Sponsored by the Donwood Foundation, Addiction Research Foundation, Toronto
- Du Bois, B. (1983): 'Passionate scholarship: notes on values, knowing and method in feminist social science', in G.Bowles & R.Duelli Klein (eds): *Theories of Women's Studies*, Routledge and Kegan Paul, London
- Dunnell, K. & Cartwright, A. (1972): *Medicine Takers, Prescribers and Hoarders*, Routledge and Kegan Paul, London
- Durkheim, E. (1952): *Suicide: A Study in Sociology*, Routledge and Kegan Paul, London
- Durkheim, E. (1964a): *Rules of Sociological Method*, Free Press, New York (first published in 1895)
- Durkheim, E. (1964b): *The Division of Labour in Society*, Free Press, New York
- Edinburgh District Council on Alcoholism (1985): *Women and Alcohol*, Conference
- Edwards, G. (1970): 'The Status of Alcoholism as a Disease' in R.V. Phillipson (ed): *Modern Trends in Drug Dependence and Alcoholism*, Butterworths, London
- Edwards, G. Hensman, C. & Peto, J. (1972): 'Drinking in a London suburb. III. comparisons of drinking troubles among men and women', *Quarterly Journal of Studies on Alcoholism*, Supplement No.6. 120-128
- Edwards, G. et al (eds) (1977): *Alcohol Related Disabilities*, WHO Offset Publication No.32

- Edwards, G. (1977): 'The Alcohol Dependence Syndrome: Usefulness of an Idea' in G. Edwards & M. Grant (eds): *Alcoholism: New Knowledge and New Responses*, Croom Helm, London
- Edwards, G. & Grant, M. (eds) (1977): *Alcoholism: New Knowledge and New Responses*, Croom Helm, London
- Ehrenreich, B. & English, D. (1973): *Complaints and Disorders: The Sexual Politics of Sickness*, The Feminist Press, Glass Mountain Pamphlet No.2, New York
- Ehrenreich, B & English, D. (1979): *For Her Own Good: 150 Years of the Experts Advice to Women*, Pluto, London
- Elder, T.C. (1973): 'Alcoholism and its onset in a population of admitted alcoholics: an AA study', *British Journal of Addictions*, 68, 291-294
- English, J. (ed) (1977): *Sex Equality*, Prentice-Hall, New Jersey
- Erikson, E.H. (1963): *Childhood and Society*, Norton, New York (first published in 1950)
- Erikson, E.H. (1968): *Identity, Youth and Crisis*, Norton, New York
- Ettorre, B. (1986): 'Women and drunken sociology: developing a feminist analysis', *Women's Studies Internations Forum*, 9, (5), 515-520
- Fee, E. (1976): 'Science and the woman problem: historical perspectives' in M.S.Teitelbaum (ed): *Sex Difference: Social and Biological Perspectives*, Doubleday, New York
- Fenichel, O. (1945): *The Psychoanalytic Theory of Neurosis*, Norton and Co, New York
- Ferrence, R.G. (1980): 'Sex differences in the prevalence of problem drinking', in O.J.Kalant (ed): *Alcohol and Drug Problems in Women: Research Advances in Alcohol and Drug Problems, Vol.5*, Plenum, New York

- Feyerabend, P.K. (1970): 'Against method: an outline of an anarchistic theory of knowledge', *Minnesota Studies in the Philosophy of Science*, 4, 17-130
- Field, P.B. (1962): 'A new cross cultural study of drunkenness', in D.J. Pittmen & C.R. Snyder (eds): *Society, Culture and Drinking Patterns*, Wiley, New York
- Foreman, A. (1977): *Femininity as Alienation: Women and the Family in Marxism and Psychoanalysis*, Pluto, London
- Fort, T. & Peterfield, A.L. (1961): 'Some backgrounds and types of alcoholism among women', *Journal of Health Human Behaviour*, 2, 282-292
- Foucault, M. (1965): *Madness and Civilization*, Pantheon
- Fox, R & Lyon, P. (1955): *Alcoholism: it's Scope and Treatment*, Random House, New York
- Fox, R. (1963): 'The effect of alcoholism on children', proceedings of the 5th International Congress on Psychotherapy, Karger, New York
- Franks, V. & Burtles, V. (eds)(1974): *Women in Therapy*, Brunner/Mazel, New York
- Fraser, W. (1975): 'The alcoholic woman: attitudes and perspectives', in A.MacLennan (ed): *Women: Their Use of Alcohol and Other Legal Drugs: A Provincial Consultation*, Addiction Research Foundation of Ontario, Toronto, Canada
- Freud, S. (1905) *Three Essays on the Theory of Sexuality*
- Freud, S. (1913): 'Totem and Taboo' in J.Strachey (ed)(1961): *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol XXI, Hogarth, London

- Freud, S. (1917): 'Mourning and Melancholia' in J. Strachey (ed) (1961): *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol IV*, Hogarth, London
- Freud, S. (1977): *On Sexuality*, Penguin, London
- Geddes, P. & Thompson, A. (1890): *The Evolution of Sex*, Schribner and Welford, New York
- Gelb, L.A. (1974): 'Masculinity-femininity: a study in imposed inequality', in J.Baker Miller (ed): *Psychoanalysis and Women*, Penguin, London
- Gelsthorpe, L. (1989): *Sexism and the Female Offender*, Gower, Aldershot
- Gomberg, E. (1974): 'Women and alcoholism' in V. Franks & V. Burtie (eds): *Women in Therapy*, Brunner/Mazel, New York
- Gomberg, E. (1976): 'Alcoholism in women' in B. Kissin & H.Beigleiter (eds): *The Biology of Alcoholism Vol 4: Social Aspects of Alcoholism*, Plenum, New York
- Gomberg, E. (1979): 'Drinking patterns of Women Alcoholics' in V.Burtie (ed): *Women Who Drink: Alcoholic Experience and Psychotherapy*, Charles C. Thomas, Illinois
- Goodwin, D.W. (1971): 'Is alcoholism hereditary?', *Archives of General Psychiatry*, 25, 545-549
- Gouldner, A.W. (1971): *The Coming Crisis of Western Sociology*, Heinemann Educational, London
- Gove, W.R. & Tudor, J.F. (1974): 'Adult sex roles and mental illness', *American Journal of Health Services*, 4, (4), 617-623
- Gramsci, A. (1971): *Selections from the Prison Notebooks*, Lawrence & Wishart, London
- Grant, M., Plant, M. & Williams, A. (eds)(1983): *Economics and Alcohol*, Croom Helm, Kent

- Greenblatt, M. & Schukit, M.A. (eds)(1976):
Alcoholism Problems in Women and Children,
Grune & Stratton, New York
- Gutzke, D.W. (1984): ''The cry of the children':
the Edwardian medical campaign against
maternal drinking', *British Journal of
Addiction*, 79, 71-84
- Hall, S. & Jefferson, T. (eds)(1974): Resistance
through Rituals
- Harding, S. (ed)(1987): *Feminism and Methodology*,
Open University Press, Milton Keynes
- Harrison, B. (1971): *Drink and the Victorians: The
Temperance Question in England 1815 - 1872*,
Faber and Faber, London
- Hartsock, N. (1987): 'The feminist standpoint:
developing the ground for a specifically
feminist historical materialism', in
S.Harding (ed): *Feminism and Methodology*,
Open University Press, Milton Keynes
- Harwin, J. & Otto, S.J. (1979): 'Women alcohol and
the screen' in J.Cook & M.Lewington (eds):
Images of Alcoholism, Tavistock, London
- Heather, N. & Robertson, I. (1981): *Controlled
Drinking*, London, Methuen
- Heather, N. (1980): 'Conventional wisdom or
radical re-think: does anything work?',
Introductory Paper to FARE Annual Symposium
- Heather, N., Whitton, B. & Robertson, I. (1986):
'Evaluation of a self-help manual for media-
recruited problem drinkers: six month follow
up results' *British Journal of Clinical
Psychology*, 25, 19-34
- Hey, V. (1986): *Patriarchy and Pub Culture*,
Tavistock, London
- Higbee, J.N. (1977): 'Rational emotive therapy in
dealing with alcohol-dependent persons', in
J.Wolfe & E.Brands (eds): *Twenty Years of
Rational Therapy: Proceedings from the First
National Conference on Rational Therapy*,
Institute for Rational Living, New York

- Hoffman-Bustamante, D. (1973): 'The nature of female criminality', *Issues in Criminology*, 8, 2
- Hornick, E.L. (1977): *The Drinking Woman*, Association Press, New York
- Horton, D. (1943): 'The function of alcohol in primitive societies: a cross cultural study', *Quarterly Journal of Studies on Alcohol*, 4, 199-320
- Horton, J. (1971): 'The fetishism of sociology', in J.Colfax & J.Roach (eds): *Radical Sociology*, Basic Books, London
- Huber, J. (ed)(1973): *Changing Women in a Changing Society*, University of Chicago Press, Chicago
- Hughes, J.A. (1976): *Sociological Analysis: Methods of Discovery*, Nelson, London
- Hume, D. (1748): *An Inquiry Concerning Human Understanding*
- Hunt, G. (1985): 'Women and the pub' in *Women's Problems with Alcohol and Other Drugs: Improving our Response*, Alcohol Interventions Training Unit/Addictions Research Unit Conference, London
- Hunt, G. (1986): 'Women and alcohol culture: the case of the alehouse and the urban pub' in *Women's Problems with Alcohol and Other Drugs: Improving our Response*, Alcohol Interventions Training Unit/Addictions Research Unit Conference, London
- Hunt, G. (1987): 'Wretched, hatless and miserably clad: women and the inebriate reformatories from 1900 - 1913', unpublished manuscript, Polytechnic of North London
- Hutter, B. & Williams, G. (eds) (1981): *Controlling Women: The Normal and the Deviant*, Croom Helm, London
- Irigaray, L. (1973): *Le Language des Dements*, Mouton, Paris

- Isaacs, J. & Moon, G. (1985): *Alcohol Problems: The Social Work Response*, Social Services Research and Intelligence Unit Report, No 13
- Isaacs, J. (1986): 'Women as clients of social services: are the individual needs of women drinkers overlooked in the concern for other family members?', in *Alcohol Interventions Training Unit and Addiction Research Unit: Women's Problems with Alcohol and Other Drugs: Improving Our Response*, Conference, London
- Iversen, L.L., Inversen, S.D. & Snyder, S. (eds) (1978): *Handbook of Psychopharmacology, Vol 12: Drugs of Abuse*, Plenum, New York
- Jacklin, C. & Mischel, H. (1973): 'As the twig is bent: sex role stereotyping in early readers', *School Psychology Digest*, 2, (3), 30-38
- Jellinek, E. M. (1952): 'Phases of alcohol addiction', *Quarterly Journal of Studies on Alcohol*, 13, 673-684
- Jellinek, E.M. (1960): *The Disease Concept of Alcoholism*, Hillhouse Press, New Haven US
- Johnson, M.W. (1965): 'Physician's views on alcoholism: with special reference to alcoholism in women', *Nebraska State Medical Journal*, 50, 378-384
- Jones, B.M. & Jones, M.K. (1976a): 'Women and alcohol: intoxication, metabolism and the menstrual cycle' in M.Greenblatt & M.A.Schukit (eds): *Alcoholism Problems in Women and Children*, Grune & Stratton, New York
- Jones, B.M. & Jones, M.K. (1976b): 'Alcohol effects in women during the menstrual cycle', *Annals of New York Academy of Science*, 273, 567-567
- Jones, M.C. (1968): 'Personality correlates and antecedents of drinking patterns in adult males', *Journal of Consulting and Clinical Psychology*, 32, 2-12

- Jones, M.C. (1971): 'Personality antecedants and correlates of drinking patterns in women', *Journal of Consulting and Clinical Psychology*, 36, 61-69
- Kalant, O.J. (ed)(1980): *Alcohol and Drug Problems in Women: Research Advances in Alcohol and Drug Problems*, Vol.5, Plenum, New York
- Karpman, B. (1948): *The Alcoholic Woman*, Linacre Press, Washington
- Keil, J.T. (1978): 'Sex role variations and women's drinking: results from a household survey in Pennsylvania, *Quarterly Journal of Studies on Alcoholism*, 39, 859-867
- Keller, M. (1972): 'The oddities of alcoholics', *Quarterly Journal of Studies on Alcohol*, 33, 1147-1148
- Keller, M. (1973): *Alcoholism in Women*, Proceedings, First Annual Conference, NIAAA, HEW
- Kessel, N. & Walton, H. (1965): *Alcoholism*, Penguin, London
- Kessel, N. (1978): *The Pattern and Range of Services for Problem Drinkers*, HMSO, London
- Kessler, C., Brown, L, & Broman, C. (1981): 'Sex differences in psychiatric help-seeking: evidence for four large-scale surveys', *Journal of Health and Social Behaviour*, 22, 49-64
- Kinsey, B.A. (1966): *The Female Alcoholic: A Social Psychological Study*, Charles, C. Thomas, Illinois
- Kinsey, B.A. (1968): 'Psychological factors in women from a state hospital sample', *American Journal of Psychiatry*, 124, 1463-1466
- Kissin, B. & Beigleiter, H. (eds)(1976): *The Biology of Alcoholism Vol 4: Social Aspects of Alcoholism*, Plenum, New York
- Kitzinger, C. (1987): *The Social Construction of Lesbianism*, Sage, London

- Knowicke, S.J.R. & Hopper, A.E. (1974): 'Locus of control correlates in an alcoholic population', *Journal of Consulting and Clinical Psychology*, 42
- Kreitman, N. (1977): 'Three themes in the epidemiology of alcoholism' in Edwards, G & Grant, M (eds): *Alcoholism: New Knowledge and New Responses*, Croom Helm, London
- Kuhn, T. (1962): *The Structure of Scientific Revolutions*, University of Chicago Press, Chicago
- Lancaster Regionalism Group (1985): *Localities, Class & Gender*, Plon, London
- Lazarsfeld, P.F. (1977): 'Evidence and inference in social research', M.Bulmer (ed): *Sociological Research Methods*, Macmillian, London
- Ledermann, S. (1956): *Alcohol, Alcoolisme, Alcoolisation' Donnees Scientifiques de Caractere Physiologique, Economique et Sociol*, Paris, Insitute Nationale Etudes Demographique
- Lemert, E. (1951): *Social Pathology*, McGraw Hill, New York
- Lennard, H.L. & Bernstein, A. (1974): 'Perspectives on the new psychotropic drug technology', in R. Cooperstock (ed): *Social Aspects of the Medical Use of Psychotropic Drugs*, ARF Books, Toronto
- Leonard, D. (1980): *Sex and Generation: A Study of Courtship and Weddings*, Tavistock, London
- Levine, H. (1975): 'On women and on one woman', in A. MacLennan (ed): *Women: Their Use of Alcohol and Other Legal Drugs: A Provincial Consultation*, Addiction Research Foundation of Ontario, Tronto, Canada

- Levine, H. (1977): 'Feminist counselling: new directions for women', in J.Dowsling & A. MacLennan (eds): *The Chemically Dependent Woman: Recognition, Referral, Rehabilitation*, Proceedings of a Conference Sponsored by the Donwood Foundation, Addiction Research Foundation, Toronto
- Levine, H.G. (1980): 'Temperence and women in nineteenth century United States', in O.J.Kalant (ed): *Alcohol and Drug Problems in Women: Research Advances in Alcohol and Drug Problems, Vol.5*, Plenum, New York
- Levis, D. (1976): 'Learned helplessness: A reply and an alternative S-R interpretation', *Journal of Experimental Psychology*, 105, 47-65
- Levy, S.J. & Doyle, K.M. (1974): 'Attitudes towards women in a drug abuse treatment programme', *Adit: Approaches to Drug Abuse and Youth*, 2, (10), New York
- Lindbeck, V.L. (1972): 'The woman alcoholic: a review of the literature', *International Journal of the Addictions*, 7 (3), 567-580
- Lisansky, E. (1957): 'Alcoholism in women: social and psychological concomitants: 1. social history data', *Quarterly Journal of Studies on Alcohol*, 18, 588-623
- Lisansky, E. (1960): 'The etiology of alcoholism: the role of psychological predisposition', *Quarterly Journal of Studies on Alcohol*, 21 (2), 314-343
- Lombroso C. (1876): *L'Uomo Delinquente*, Hoepl, Milan
- Lombroso, C. & Ferrero, W. (1895): *The Female Offender*, Fisher Unwin, London
- Maccoby, E. & Jackin, C. (1974): *The Psychology of Sex Differences*, Stanford University Press, Stanford
- Madden, J., Walker, B., & Keynon W. (eds)(1980): *Aspects of Alcohol Problems*, Pitman Medical, Tunbridge Wells

- Makela, K. (1975): 'Consumption level and cultural drinking patterns as determinants of alcohol problems', *Journal of Drug Issues*, 5, 344
- Marcuse, H. (1964): *One Dimensional Man*, Routledge and Kegan Paul, London
- Maris, R.W. (1971): 'Deviance as therapy: The paradox of the self-destructive female', *Journal of Health and Social Behaviour*, 12, 113-124
- Mark-Lawson, J., Savage, M. & Warde, A. (1985): 'Gender & local politics: struggles over welfare policies', in Lancaster Regionalism Group: *Localities, Class & Gender*, Pion, London
- Martin, E. (1987): *The Woman in the Body: A Cultural Analysis of Reproduction*, Open University Press, Milton Keynes
- Massot, H. (1957): 'Female alcoholism', *Quarterly Journal of Studies on Alcohol*, 18, (1), 144
- Matthews, R. & Young, J (eds) (1986): *Confronting Crime*, Sage, London
- Mayfield, D. (1968): 'Psychopharmacology of alcohol: affective change with intoxication, drinking behaviour and affective states', *Journal of Nervous Mental Disorders*, 146, 314-321
- Mayne, B, (1986): 'Controlled drinking: the issues for women who drink at home', *Women's Problems with Alcohol and Other Drugs: Improving our Response: Proceedings of a Conference held by The Alcohol Interventions Training Unit with the Addiction Training Unit*, London
- Mello, N.K. & Mendelson, J.H. (1965): 'Operant analysis of drinking habits of chronic alcoholics', *Nature*, 206, 43-46
- Mello, N. & Mendelson, J.H. (1978): 'Alcohol and human behaviour' in L.L.Iverson et al (eds): *Handbook of Psychopharmacology, Vol 12: Drugs of Abuse*, Plenum, New York

- Mello, N.K. (1980): 'Some behavioural and biological aspects of alcohol problems in women' in O.J.Kalant (ed): *Alcohol and Drug Problems in Women: Research Advances in Alcohol and Drug Problems, Vol.5*, Plenum, New York
- Mendelson, J.H. & Mello, N.K. (1979): 'Biological comcomitants of alcoholism', *New England Journal of Medicine*, 301, 912-921
- Menninger, K. (1938): *Man Against Himself*, Harcourt, Brace and Co., New York
- Middleton, L. (ed) (1978): *Women in the British Labour Movement*, Croom Helm, London
- Mill, J.S. (1921): *Principles of Political Economy with some of their Applications for Social Philosophy*, Green and Co. London (first published 1884)
- Mill, J.S. (1965): *The Subjection of Women*, Everyman's Library
- Miller, J.B. (ed)(1973): *Psychoanalysis and Women*, Penguin, New York
- Miller, I & Norman, W. (1979): 'Learned helplessness in humans: a review and attribution theory model', *Psychological Bulletin*, 86, (1), 93-118
- Ministry of Health (1962): *Hospital Treatment for Alcoholics*: Memorandum HM (62), 43
- Moi, T. (1985): *Sexual/Textual Politics: Feminist Literary Theory*, Methuen, London
- Moos, R.H. (1969): 'Typology of menstrual cycle symptoms', *American Journal of Obstetrics and Gynecology*, 103, 390-401
- Morgan, D. (1981): 'Men, masculinity and the process of sociological enquiry', in H.Roberts (ed): *Doing Sociological Research*, Routledge and Kegan Paul, London
- Mulford, H.A. (1977): 'Women and men problem drinkers', *Journal of Studies on Alcohol*, 38, 1624-1639

- MacAndrew, C. & Edgerton, R.B. (1969): *Drunken Comportment: A Social Explanation*, Thomas Nelson and Sons
- MacLennan, A. (ed) (1975): *Women: Their Use of Alcohol and Other Legal Drugs: A Provincial Consultation*, Addiction Research Foundation of Ontario, Toronto, Canada
- McClelland, D.C., Davies, W.M., Kalin, R. & Wanner, E. (1972): *The Drinking Man*, Free Press, New York
- McCord, W & McCord, J. (1960): *The Origins of Alcoholism*, Tavistock
- McCord, W. & McCord, J. (1962): 'A longitudinal study of the personality of alcoholics' in D.J. Pittman & C.R. Snyder (eds): *Society, Culture and Drinking Practices*, Wiley, New York
- McRobbie, A. (1980): 'Settling accounts with subcultures', *Screen Education*, 34, 37-49
- McRobbie, A. & McCabe, T. (eds) (1981): *Feminism for Girls: An Adventure Story*, Routledge and Kegan Paul, London
- McRobbie, A. (1982): 'The politics of feminist research: between talk, text and action', *Feminist Review*, 12, October 1982
- Nathenson, C. (1975): 'Illness and the feminine role: a theoretical review', *Social Science and Medicine*, 9, (2), 57-62
- Orford, J. (1977): 'Alcoholism: what psychology offers', in G. Edwards & M. Grant (eds): *Alcoholism: New Knowledge and New Responses*, Croom Helm, London
- Otto, S. (1980): 'Single homeless women and alcohol', in Camberwell Council on Alcohol: *Women and Alcohol*, Tavistock, London
- Otto, S. (1981): 'Women, alcohol and social control' in B. Hutter & G. Williams (eds): *Controlling Women: The Normal and the Deviant*, Croom Helm, London

- Paige, K. (1973): 'Women learn to sing the menstrual blues', *Psychology Today*, September 1973
- Page, C.H. (ed)(1966): *Sociology of Contemporary Education*, Random House, New York
- Paredes, A. et al (1969): ' A clinical study of alcoholics using audio-visual self-image feedback', *Journal of Nervous Disorders*, 148, 449-456
- Parker, F.B. (1972): 'Sex-role adjustment in women alcoholics', *Quarterly Journal of Studies on Alcohol*, 33, 647-657
- Parsons, T. & Bales, R.F. (1956): *The Family, Socialisation and Interaction Process*, Routledge and Kegan Paul
- Pattison, E.M. (1966): A critique of alcoholism treatment concepts: with special reference to alcoholism', *Quarterly Journal of Studies on Alcohol*, 23, 49-71
- Pattison, E.M. (1976): 'A conceptual approach to alcoholism treatment goals', *Addictive Behaviours*, 1976, (1), 177-192
- Pattison, E.M., Sobell, M.B. & Sobell, L.C. (eds) (1977): *Emerging Concepts of Alcohol Dependence*, Springer Publishing Co.
- Pemberton, D.A. (1967): 'A comparison of the outcome of treatment in male and female alcoholics', *British Journal of Psychiatry*, 113, 497
- Perry, L. (1979): 'Women and drug use: an unfeminine dependency', Institute for the Study of Drug Dependence, London
- Phillips, D.L. & Segal, B.E. (1969): 'Sexual status and psychiatric symptoms', *American Sociological Review*, 34, 1, 58-72
- Phillips, D.L. (1973): *Abandoning Method*, Jossey Bass, San Francisco

- Phillipson, R.V. (ed)(1970): *Modern Trends in Drug Dependence and Alcoholism*, Butterworths, London
- Pinder, L. (1977): 'Getting in touch with the chemically dependent woman', in J.Dowsling & A.MacLennan (eds): *The Chemically Dependent Woman: Recognition, Referral, Rehabilitation*, Proceedings of a Conference Sponsored by the Donwood Foundation, Addiction Research Foundation, Toronto
- Pittman, D.J & Snyder C.R. (eds) (1962): *Society, Culture and Drinking Practices*, Wiley, New York
- Pittman, D.J. (ed) (1967): *Alcoholism*, Harpers and Row
- Plant, M. (1980): 'Women with drinking problems', *British Journal of Psychiatry*, 37, 189-290
- Plant, M. (ed) (1982): *Drinking and Problem Drinking*, Junction Books, London
- Podolsky, E. (1963): 'The woman alcoholic and premenstrual tension', *Journal of the American Medical Women's Association*, 18, 816-818
- Popham, R.E. & Schmidt, W. (1958): *Statistics of Alcohol Use and Alcoholism in Canada: 1871-1956*, University of Toronto Press, Toronto
- Popper, K.R. (1959): *The Logic of Scientific Discovery*, Hutchison, London
- Popper, K.R. (1963): *Conjectures and Refutations: The Growth of Scientific Knowledge*, Routledge and Kegan Paul, London
- Potter, J. (1979): 'Women and sex - it's enough to drive them to drink!' in V. Burtle (ed): *Women Who Drink: Alcoholic Experience and Psychotherapy*, Charles C. Thomas, Illinois
- Rathrod, N.H. & Thomson, I.G. (1971): 'Women alcoholics: a clinical study', *Quarterly Journal of Studies on Alcoholism*, 32, 45-52

- Reid, I. & Wormald, E. (eds) (1981): *Sex Differences in Britain*, Grant McIntyre, London
- Reinharz, S. (1983): 'Experiential analysis: a contribution to feminist analyses', in G.Bowles & R.Duelli Klein (eds): *Theories of Women's Studies*, Routledge and Kegan Paul, London
- Ricardo, D: *On the Principles of Political Economy and Taxation*
- Rich, A. (1977): Forward: conditions for work: the common world if women', in S.Ruddick & P.Daniels: *Working It Out*, Norton, New York
- Rich, A. (1979): *On Lies, Secrets and Silence*, Norton, New York
- Roberts, H. (ed)(1981): *Doing Feminist Research*, Routledge and Kegan Paul, London
- Robinson, D. (1976), *From Drinking to Alcoholism: A Sociological Commentary*, John Wiley and Sons
- Robinson, D. (1977): 'Factors influencing alcohol consumption', in G. Edwards & M. Grant (eds): *Alcoholism: New Knowledge and New Responses*, Croom Helm, London
- Rohsenow, D. & O'Leary, M. (1978): 'Locus of control: research on alcoholic populations', *International Journal of the Addictions*, 13, (1), 55-78
- Room, R. (1972): 'Comment on the alcoholologists addiction', *Quarterly Journal of Studies on Alcohol*, 33, 1049-1059
- Room, R. (1977) in G. Edwards et al (eds): *Alcohol Related Disabilities*, WHO Offset Publication No.32
- Room, R. (1983): 'Paternalism, rationality and the special status of alcohol', in M.Grant, M.Plant & A.Williams (eds): *Economics and Alcohol*, Croom Helm, Kent

- Rose, A.M. (ed) (1971): *Human Behaviour and Social Processes*, Routledge and Kegan Paul, London
- Rosenberg, M. (1977): 'The meaning of relationships in social-survey analysis', in M.Bulmer (ed): *Sociological Research Methods*, Macmillan, London
- Royal College of Psychiatrists (1979): *Alcohol and Alcoholism*, Tavistock, London
- Ruddick, S. & Daniels, P. (1977): *Working It Out*, Norton, New York
- Saunders, B. (1980): 'Psychological aspects of women and alcohol' in Camberwell Council on Alcohol: *Women and Alcohol*, Tavistock, London
- Sciada, J & Vannicelli, M. (1978): 'Sex role conflict and women's drinking, *Journal of Studies on Alcohol*, 10, (1), 28-44
- Schmidt, W. & De Lint, J. (1969): 'Mortality experiences of male and female alcoholic patients', *Quarterly Journal of Studies on Alcohol*, 30, 112-118
- Schmidt, W. (1977): 'Cirrhosis and alcohol consumption: an epidemiological perspective', in G.Edwards & M.Grant (eds): *Alcoholism: New Knowledge and New Responses*, Croom Helm, London
- Schuckit, M.A., Pitts, F.N. Jr, Reich, T. et al (1969): 'Alcoholism 1: two types of alcoholism in women', *Archives of General Psychiatry*, 20, 301-306
- Schuckit, M. (1972): 'The woman alcoholic: a literature review', *Psychiatry in Medicine*, 3, (1), 37-43
- Schuckit, M.A. & Gunderson, E.K. (1975): 'Alcoholism in navy and marine corps women: a first look', *Military Medicine*, 140, (4), 268-271
- Schuckitt, M.A. & Morrissey, E.R. (1979a): 'Psychiatric problems in women admitted to an alcoholic detoxification centre', *American Journal of Psychiatry*, 136:413

- Schuckitt, M.A. & Morrissey, E. R. (1979b): 'Drug abuse among alcoholic women', *American Journal of Psychiatry*, 136:413
- Schuckitt, M.A. (1983): 'Alcoholic patients with secondary depression', *American Journal of Psychiatry*, 140:6
- Sclare, A.B. (1970): 'The female alcoholic', *British Journal of Addiction*, 65, 99-107
- Scull, A.T. (1982): *Museums of Madness: The Social Organisation of Insanity in the Nineteenth Century*, Harmondsworth
- Seligman, M. (1975): *Helplessness: On Depression, Development and Death*, Freeman, San Francisco
- Shaw, S.J., Cartwright, A.K.J., Spratley, T.A. & Harwin, J. (1978): *Responding to Drinking Problems*, Croom Helm, London
- Shaw, S. (1980): 'The causes of increasing drinking problems among women: a general etiological theory', in Camberwell Council on Alcohol: *Women and Alcohol*, Tavistock, London
- Shaw, S. (1982): 'What is problem drinking?' in M. Plant (ed): *Drinking and Problem Drinking*, Junction Books, London
- Sheehan, M. & Watson, J. (1980): 'Response and recognition', in Camberwell Council on Alcohol: *Women and Alcohol*, Tavistock, London
- Showalter, E. (1987): *The Female Malady: Women, Madness and English Culture 1850-1980*, Virago, London
- Silkworth, W.D. (1937): 'Alcoholism as manifestation of allergy', *Medical Records* 249
- Smart, C. & Smart, B. (eds)(1978): *Women, Sexuality and Social Control*, Routledge and Kegan Paul, London
- Smart, B. (1976): *Sociology, Phenomenology and Marxian Analysis*, Routledge and Kegan Paul, London

- Smart, C. (1976): *Women, Crime and Criminology*, Routledge and Kegan Paul, London
- Smart, C. (1984): 'Social policy and drug addiction: a critical study of policy development', *British Journal of Addiction*, 79, 31-39
- Smigel, E.O. (ed) (1963): *Work and Leisure*, College and University Press, New Haven, Conn.
- Smith, A. (1776): *The Wealth of Nations*
- Smith, B. (1986): 'Working with women drug and alcohol users in groups: a description of an out-patient 'coping skills' group at a New Zealand centre', Alcohol Interventions Training Unit and Addiction Research Unit: *Women's Problems with Alcohol and Other Drugs: Improving our response*, Conference, London
- Smith, D. (1977): 'Women's perspective as a radical critique of sociology', *Sociological Inquiry*, 44, (1), 7-13
- Sontag, S. (1978): *Illness as Metaphor*, Allen Lane, London
- Spender, D. (1978): 'Education, research and the feminist perspective' unpublished paper to the British Educational Research Association Conference on Women, Education and Research, University of Leicester
- Stacey, M. (1988): *The Sociology of Health and Healing*, Unwin Hyman, London
- Stafford, R. (1979): 'Alcoholics Anonymous and the woman alcoholic', in V.Burtle (ed): *Women Who Drink: Alcoholic Experience and Psychotherapy*, Charles C. Thomas, Illinois
- Stanley, L. & Wise, S. (1983): *Breaking Out*
- Steiner, M. & Carroll, B.J. (1977): 'The psychobiology of premenstrual dysphoria: review of theories and treatments', *Psychoneuroendocrinology*, 2, 321-335

- Strachey, J. (ed) (1961): *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol XXI*, Hogarth, London
- Swallow, J. (ed) (1983): *Out from Under: Sober Dykes and Our Friends*, Spinsters Ink, San Francisco
- Swallow, J. (1983b): 'What is Calistoga?', in J. Swallow (ed): *Out from Under: Sober Dykes and Our Friends*, Spinsters Ink, San Francisco
- Swinson, R.P. (1980): 'Sex differences in the inheritance of alcoholism' in O.J.Kalant (ed): *Alcohol and Drug Problems in Women: Research Advances in Alcohol and Drug Problems, Vol.5*, Plenum, New York
- Taylor, I., Walton, P., & Young, J. (1973): *The New Criminology: For a Social Theory of Deviance*, Routledge and Kegan Paul, London
- Teitelbaum, M.S.(ed) (1976): *Sex Difference: Social and Biological Perspectives*, Doubleday, New York
- Thom, B. (1984): 'A process approach to women's use of alcohol services', *British Journal of Addiction*, 79, 377-382
- Thom, B. (1986a): 'Sex differences in help-seeking for alcohol problems: 1. the barriers to help-seeking', *British Journal of Addiction*, 81, 777-788
- Thom, B. (1986b): 'Gateways to treatment', in Alcohol Interventions Training Unit and Addiction Research Unit: *Women's Problems with Alcohol and other Drugs: Improving our Response*, Conference, London
- Thomas, W.I. (1967): *The Unadjusted Girl*, Harper & Row, New York
- Tuck, M. (1980): *Alcoholism and Social Policy: Are We on the right Lines*, Home office Research Study No.65, HMSO, London
- Vicinus, M. (1985): *Independent Women: Work and Community for Single Women 1850-1920*, Virago, London

- Walby, S. (1990): *Theorising Patriarchy*, Blackwell, London
- Weideger, P. (1978): *Female Cycles*, The Womens Press, London
- Weisstein, N. (1977): 'Psychology constructs the female', in J. English (ed): *Sex Equality*, Prentice-Hall, New Jersey
- Westkott, M. (1983): 'Women's studies as a strategy for change', in G.Bowles & R.Duelli Klein (eds): *Theories of Women's Studies*, Routledge and Kegan Paul, London
- White, R. (1948): *The Abnormal Personality*, Roland Press, New York
- Whitehead, A. (1976): 'Sexual antagonism in Hereford' in D.Barker and S.Allen (eds): *Dependence and Exploitation in Work and Marriage*, Longman, London
- Whitehead, P.C. & Ferrence, R.G. (1980): 'Women and children last: implications of trends in consumption for women and young people, in M.Greenblatt & M.A.Schukit (eds): *Alcoholism Problems in Women and Children*, Grune & Stratton, New York
- Wilcoxon, L.A., Schrader, S.L. & Sherif, C.W. (1976): 'Daily self-reports on activities, life-events, moods and somatic changes during the menstrual cycle', *Psychomatic medicine*, 38, 399-417
- Wilkinson, P. (1980): 'Sex differences in the morbidity of alcoholics' in O.J.Kalant (ed): *Alcohol and Drug Problems in Women: Research Advances in Alcohol and Drug Problems*, Vol.5, Plenum, New York
- Williams, A. (1966): 'Social drinking, anxiety and depression', *Journal of Personality and Social Psychology*, 10, 91-97
- Willis, P.E. (1975): 'The cultural meaning of drug use', in S. Hall & T. Jefferson (eds): *Resistance through Rituals*

- Willowroot, A. (1983): 'Creativity, politics and sobriety' in J. Swallow (ed): *Out from Under: Sober Dykes and Our Friends*, Spinsters Ink, San Francisco
- Wilsnack, S. (1973a): 'The needs of the female drinker: dependency, power, or what?', *Psychological and Social Factors in Drinking and Treatment and Treatment Evaluation*, Proceedings of the Second Annual Conference of the National Institute on Alcohol Abuse and Alcoholism, National Institute of Mental Health, Rockville.
- Wilsnack, S. (1973b): 'Sex role identity in female alcoholism', *Journal of Abnormal Psychology*, 82, 253-261
- Wilsnack, S. (1976): 'The impact of sex roles on women's alcohol use and abuse' in M.Greenblatt & M.A.Schukit (eds): *Alcoholism Problems in Women and Children*, Grune & Stratton, New York
- Wilson, E. (1987): 'Psychoanalysis: psychic law and order', in Feminist Review (ed): *Sexuality: A Reader*, Virago, London
- Wilson, P. (1980): *Drinking in England and Wales*, HMSO, London
- Winch, P. (1958): *The Idea of Social Science*, Routledge and Kegan Paul, London
- Winokur, G. & Pitts, F.N.Jr. (1965): 'Affective disorder, VI, a family history of prevalences, sex differences and possible genetic factors', *Journal of Psychiatric Research*, 3, 113-123
- Winokur, G, Clayton, P. & Reich, T. (1969) *Manic Depressive Illness*, Mosby, St Lewis
- Wolff, K. (ed) (1960): *Emile Durkheim et al: Writings on Sociology and Philosophy*, Harper and Row, New York

- Wolfe, J. & Brands, E. (eds) (1977): *Twenty Years of Rational Therapy*: Proceedings from the first national conference on rational therapy, Institute for Rational Living, New York
- Wolfe, J. (1979): 'A Cognitive/behavioural approach to working with woman alcoholics' in V. Burtie (ed): *Women Who Drink: Alcoholic Experience and Psychotherapy*, Charles C. Thomas, Illinois
- Wolfson, D. & Murray, J. (eds) (1986): *Women and Dependency: Women's Personal Accounts of Drug and Alcohol Problems*, D.A.W.N., London
- Woodruff, R.A., Guze, S.B. & Clayton, P.J. (1973): 'Alcoholics who see a psychiatrist compared with those who do not', *Quarterly Journal of Studies on Alcohol*, 34, 1162-1171
- Worrall, A. (1990): *Offending Women: Female Lawbreakers and the Criminal Justice System*, Routledge and Kegan Paul, London
- Young, J. (1971): *The Drugtakers: The Social Meanings of Drug Use*, Paladin, London
- Zola, I.K. (1972): 'Medicine as an institution of social control', *Sociological Review*, 4